WORKING WITH OLDER PEOPLE

Volume III

THE AGING PERSON: NEEDS AND SERVICES

a guide to practice

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RTMENT OF HEALTH, EDUCATION, AND WELFARE • PUBLIC HEALTH SERVICE

WORKING WITH OLDER PEOPLE:

A Guide To Practice

Volume I: The Practitioner and the Elderly

Volume II: Biological, Psychological, and Sociological Aspects of Aging

Volume III: The Aging Person: Needs and Services

Volume IV: Clinical Aspects of Aging

The volumes in this series were prepared from materials developed by the Projects Division, Gerontological Society, under contract PH 86–63–184 with the Public Health Service.

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THE AGING PERSON: NEEDS AND SERVICES

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, Public Health Service, Health Services and Mental Health Administration, Community Health Service, Division of Health Care Services, Rockville, Maryland 20852
April 1970

FOREWORD

"Working With Older People: A Guide to Practice" will, upon completion, be a series of four volumes designed as resource material for health practitioners who work with the elderly. This series is based principally on materials developed by the Gerontological Society under contract with the Public Health Service.

Volume I, "The Practitioner and the Elderly," * focuses on aging and the world of practice related to aging. The publication puts into perspective the changing character and needs of the aging population and the implications of these changes for required programs and services. The many interdependent needs of the elderly are identified and correlated with areas of interdependence among practitioners who seek to meet these needs.

Volume II, "Biological, Psychological, and Sociological Aspects of Aging," is devoted to the basic sciences most directly related to the process of aging and the aged individual. *Biological aspects of aging* are discussed in terms of those physical characteristics which are affected by time and determined largely by genetic and environmental influences brought to bear on the individual. *Psychological aspects of aging* are discussed in terms of those functions used by the individual in adapting to his environment—his senses and perception, his ability to learn and remember, his responses, and his personality. *Sociological aspects of aging* are discussed in terms of the adjustment of the aged individual to society, with consideration given to the degree to which he is, or can be, influenced by family, friends, and community.

Volume III, "The Aging Person: Needs and Services," deals with social welfare as it relates to health of the aged, and identifies those factors—biological, psychological and sociological—which significantly affect the aging process.

Volume IV, "Clinical Aspects of Aging," consists of: (1) a section dealing with disease conditions most relevant to single organ systems of the elderly; (2) a section dealing with the subjects of metabolism, nutrition, rehabilitation, drug therapy and laboratory values; and (3) a section dealing with special professional practices and the elderly person, including surgery, dentistry, nursing, physical therapy, occupational therapy and podiatry.

Special recognition is made of the efforts of Dr. Austin B. Chinn, formerly Chief of the Adult Health Protection and Aging Program, who recognized the need for these materials and who developed the means for producing them.

It is hoped that "Working With Older People: A Guide to Practice" will serve as a useful tool in continuing education activities which are so vitally needed to enrich the understanding of health professionals who work with aging and aged persons.

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MATCHING SERVICES TO INDIVIDUAL NEEDS OF THE AGING

by
Walter M. Beattie, Jr., M.A.*

In evaluating the concept of "matching services to individual needs," it is important to address ourselves to several basic questions. Why the use of the terminology *aging* rather than *aged?* Why our present concern with individualization of services? What are the "needs" to which services are addressed? How can such services be put into "context" by relating services to the world and reality of the older individual?

DIMENSIONS OF AGING

First, why the terminology *aging* rather than *aged?* When is a person old? There are persons in their advanced years who are regarded as young—in heart, appearance, and/or attitude. On the other hand, we have all known persons in their middle years who somehow have always seemed "old." Aging is relative and has many dimensions. Several of these dimensions are explored below.

Psychological Dimension

Certainly there is the psychological dimension of aging; that is, one's perceptual and learning abilities. The familiar saying, "You can't teach an old dog new tricks" is a stereotype of aging. It reflects the belief that older persons can no longer adjust or adapt to change and cannot learn to live with new ideas or knowledge. This theory, however, is invalid. While it is true that people may have increasing impairment of eyesight and hearing with advancing years, we also know that a person continues to learn as long as he lives.

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It is important to recognize that older persons continue to adjust to new situations and can learn far more than we are likely to acknowledge. No other generation in the history of mankind has had so many changes to adapt to as our present generation of older persons.

Physiological Dimension

The biologist tells us that aging, biologically speaking, is a relative process; that is, persons at any particular birthday may be more different than they are alike. Also, it is interesting to note that each one of us ages differently within our own organisms. I may have a younger heart than you, but you may have a younger kidney than I. Tissue and organ banks and live transplants may make it possible to keep persons alive for a much longer period of time than heretofore as we replace aged organs with younger counterparts. Biologists believe that the human organism could attain a life expectancy of 125 years and we do know that we have an increasing number of persons passing the 100 year mark.[1]

Many of our 65-year-olds today are more like their 50-year-old counterparts at the turn of the century due to improved nutrition, health care, and environmental sanitation. Today's generation of older persons is physiologically younger than its counterpart at the turn of the century. Whistler's Mother, who epitomizes "old age," was 44 years of age when she sat for that famous painting.

Chronological Dimension

Because of our mass society, we have a tendency to categorize a person in terms of his chronological age. Many of our social policies are based upon the mistaken notion that only birthdays count and that all persons of the same chronological age are essentially alike. It is interesting to note the change in retirement eligibility for Old Age and Survivors Disability

Insurance, permitting men as well as women to retire at age 62 with a reduced benefit. We are beginning to see the evolvement of a new social policy: 62 years as the age for retirement.

Sociological Dimension

The sociological dimension may be defined in terms of the social function which a person performs in his family or society. Many of the difficult situations of the aging are related to this dimension in that society's values and attitudes determine our behavior.

The worker in his middle years, skilled to perform specific tasks, finds it nearly impossible to re-enter the labor force without retraining. Economist Chamberlain discussed the root of this problem and its increasing applicability to the white collar professions.

"The fundamental change which has taken place in our culture is a speeding up of the rate of accumulation of knowledge, and acceleration so much in excess of what we have been accustomed to that it is imposing unexpected strains . . .

"The new knowledge will be in the possession of a younger man who will have just come through a period of instruction that had winnowed out the older, less useful knowledge and substituted for it the new, more relevant knowledge. And then that younger man, once on a job, will himself begin the process of professional deterioration." [2]

Functionally, in regard to work roles, one is aged at an even younger chronological age. This factor alone requires much reconsideration of the function of education in our society. Is education something acquired in the early years and, in a sense, completed? Or, is it a lifetime process, basic both to the individual and to his society?

Dimension of Individuality

All of the above dimensions are important because they give perspectives to aging. We are concerned with the aging process as it affects individuals and families. We are concerned with the changes of aging as they interfere with or impinge upon the ability of individuals and families to be self-reliant, to make choices, and to participate in and contribute to the broader social life of the community.

Our goal too often has been to provide a service or plan a community program for older persons as an end in itself. Any service—any program—must permit alternatives of choice based upon present and predictable changing individual requirements and preferences. Where we have developed and provided services for older persons, such services have failed to view the essential unique and individual characteristics of older persons. As Gerontologist Randall has stated:

"The major characteristic of older people is that of being extraordinarily individualistic. Each person is in himself the 'sum of all his days,' of what he has done with them, and what they have to him. He is totally different from every one of his fellows—even from members of his own family who have been exposed to the very same influences and events. This leaves any generalizations about the personal, financial, and social characteristics of this large number of persons open to the usual specific exceptions which are supposed to prove the rule. It also makes the task of individualization of treatment and of creating the proper milieu for treatment—whether in or out of hospital—an extremely difficult one with serious implications for change in current methods." [3]

The great differentiation through life experiences of older persons of the same categorical age means they are more individualized and more unique than persons of earlier age groups. The processes of aging—biological, psychological, sociological—interact with physical and social environment. Individualization is the result.

Further, when we talk about the aging, we focus on a segment of the population which spans anywhere from one-fifth to one-fourth of the total lifespan. Too often we have compared and developed services for older persons such as the 65-year-old and the 85-year-old as if their needs were essentially alike, without recognizing their distinct differentials.

The emphasis inherent in the concept of matching services to individual needs must be on the right choice. The community, its social institutions and their representatives must offer a broad range of services which permits alternative choices. Therefore, while meeting particular needs of a particular situation, services must be focused on not only maintaining the present but also on creating new social goals and dimensions in the life of that person. Also important is the availability of related services and facilities such as substitute family care and congregate housing, among others. If we recognize the importance of individualization of services as essential to older persons, there is the consequent implication that community services must be related and so organized to provide choice and alternatives for the individual; that is, the goal of a community program should be "the right service, in the right place, at the right time" for the individual in need.

PRIMARY SOCIETAL VALUES

To be sensitive to the needs to which services are addressed, we must recognize some of the primary values of our society which are the yardsticks by which we measure the significance of such needs. Such values also have prevented us, at times, from perceiving the unique individual requirements of the older individual. Through society's values, that is, those goals which we as a people hold to be desirable or valuable or those which we seek to avoid, we have placed obstacles in the way of older persons participating in family and community life. What are some of these values which tend to create problems to the older individual, his family, community, and nation?

Worship of Youth

In our society, to be young is to be desirable and worthy of acceptance. This we see all about us, especially in advertising with its emphasis upon the use of cosmetics, dyes, and powders to hide the traces of aging. The woman in her 70's who attempts to dress like a teenager reflects this value. And neither are males excluded. The number of service clubs with projects for the youth as compared to the aging is a communal manifestation of this same concept.

Faith in Progress and Social Change

In an agricultural society, the older person represented knowledge and experience to situations which recurred for each of the generations. The older person had self-esteem. Prestige was conferred upon him because he had a role to perform as the repository of knowledge out of which grew wisdom. This is not so in our urban society. With rapid technological change there is a constant requirement for new knowledge. The older person represents tradition while we make a fetish of innovation and change. His opinions are devalued and his wisdom discounted. We turn our backs upon yesterday and believe that youth represents a better tomorrow.

Productivity or Work

Productivity or work is another dominant value, as opposed to leisure in our society. Many people in our society have feelings of guilt about the prospect of retirement. Work represents more than earning a living, and yet our emphasis is that in order to be worthy, one must contribute economically or be productive. We have failed to define the role of retirement in our society or what is an acceptable alternative to work.[4]

Independence

Another value which seems of import is independence. In American society we place much emphasis on the individual as he matures, moving from dependency to independence. Yet, we fail to note that much of what happens to the individual in his later years moves him from a state of independence to one of dependence. Perhaps nothing is more difficult for the older person to accept than the gradual loss of independence. In our programs of public assistance and in many of our statistical appraisals of our population, the label of "dependent" is placed on those over 65 years. We do little to identify how older people may remain independent and participating members of the community when their traditional mode of living is no longer possible.

"Togetherness"

The question may be raised with regard to who should be "together." We say that it is ideal for the nuclear conjugal family—husband, wife and children—to live together in a separate household; that it is not best for adult children and their parents, especially after these adult children have married, to live together. We then raise the question, "Togetherness for whom?" Man is a social animal; that is, to be human he must participate in the human group. Yet aging in our society tends to isolate the individual from the group.

Some of the typical life situations which face most aging persons and which move them more and more toward a socially isolated situation include:

1. *Bereavement*, especially for women. The typical older man is married and lives with his spouse. The typical older woman, however, is widowed, living alone or with her daughter and her daughter's family.
2. *Retirement*, as it separates the man from the work group relationship.
3. *Income reduction*, for it costs money to participate in social activities of the community.
4. *Loss of physical function*, which serves to increasingly limit social contacts for the older person.
5. *Social mobility*, which tends increasingly to separate the lives of the aged from those of their children when these children move to where the job is.

While the above factors work against the older person's participation in the community, we must recognize that many of them do not occur until well after the individual reaches 65. The hard to solve "problem"

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aspects of aging are with the 75-and-older age group, although there are persons in the 60's who find life most difficult.

As a reaction to this tendency of isolating older people, we see, on the other hand, many older persons forming their own age-based organizations such as "golden age" or "senior citizens" groups. Many of these organizations appear to be a reaction to the "rejection" of the aging and aged on the part of society.

SOCIAL AND CULTURAL APPROACHES

Within the context of society and its value, it is important to note that the needs of the aging are the needs of persons of all age groups. All human beings, regardless of age, have adaptive and survival needs which must be met. These may be classified under three broad categories: man in interaction with his environment; man in interaction with others; man in interaction with the unknown. All are affected by the aging processes—biological, psychological, and sociological. All practitioners working with older persons should have knowledge of these needs as they are conditioned and modified by the aging processes. Such knowledge is a prerequisite to an understanding of how such needs will be met.

For example, basic needs for man in interaction with his environment are food, clothing, and shelter. Let us take the specific of food. Food is the object, nutrition relates to biological needs, and eating is the social behavior. Are we aware that there are changing requirements in the food needs of older people, both calorically and metabolically? Do we understand the restorative requirements of diet as related to disease, or its preventive aspects in relation to degenerative illnesses? Food has cultural significance as it relates to ethnic, regional, and religious backgrounds of the individual. Psychologically, food may be a compensation or substitute for other unmet needs or losses, such as loneliness, rejection, or death of a loved one. Food has social meanings—eating in groups; offering food as a "gift"; a festive occasion. Yet aging, and too often the concomitant of social isolation in our culture, negates the fulfillment of the bio-psycho-social needs of the individual through such an obvious factor as food. Malnutrition, dehydration and anemias are prevalent among the aged in our affluent society.

Social and cultural approaches to "aging" and being "old" categorize the individual because of the situation through which we approach him. We fail to differentiate and individualize our approach to *his* needs. For example, in public welfare the means test requires that to be eligible for public assistance, the individual *must* meet the standardized definitions of the program. Once he becomes a "case" and is "on the rolls," his needs and requirements are determined and dictated by "the book." Too often, admissions and eligibility policies and practices to congregate housing and institutional care for older persons relate not to the essential needs of the older person, but rather to whether he meets the requirements and needs of the institution.

An example of our rigidities in recognizing and being able to respond to the needs of the individual was the ruling of the Public Housing Administration, now changed, that a single individual did not constitute a family and was ineligible to live in public housing. When one of an elderly couple died, not only was the survivor faced with the adjustment to the loss of a spouse, but he or she had to move, losing the social supports of neighbors and friends, and probably facing the additional adjustment to reduced income.

Parent-child Relationship

Although we emphasize the parent-child relationship as the focus of family life, we have not come to grips with the meaning of the four-generation family for such a relationship. With the extension of the lifespan for more and more individuals, we see increasing conflicts in the definition of intergenerational responsibilities. In dealing with the long-term illness of an older family member, we often see decisionmaking based upon role reversals, with the child placing himself in the decisionmaking role of the parent.

It also raises questions with regard to the two-generation aged family. An example would be the 65-year-old who is facing retirement—with consequent income reduction—and at the same time is concerned about how to pay for long-term medical or institutional care for his 85-year-old parent(s). Paradoxically, evidence indicates that parents still view themselves as having responsibility toward their children regardless of aging, while at the same time children are caught in a mesh of intergenerational responsibilities, all of which they would like to assume if they could.[5]

The question of economic responsibilities for the long-term care of the aged is one of the key issues in financing long-term illness. That children are no longer responsible for their aged parents is refuted by the evidence at hand.[6]

Subcultural and Community Impact Context

To place the older individual in the context of his family and this relationship in the context of his cultural life is essential if we are going to individualize our services to him. What does it mean to be aged and Black at the same time in our culture? How does a tradition of religious training and culture such as that of an Orthodox Jew affect the meaning of services, their settings, and their content?

What does it mean to own a home in a section of the city where urban renewal occurs, or highway construction either condemns its existence or isolates it through its concrete "Berlin-like" walls into a ghetto—removed from once familiar contacts and relationships? And, what does it mean to be relocated into a rootless world of strangers, unfamiliar faces, and unknown social institutions?

What does it mean to live in the once active central areas of the city, now called the core-city, from which all too often the social agencies, churches, and other familiar institutions are moving out to the suburbia of the younger families and their needs? Finally, what does it mean to have new social and cultural groups "move in" to the neighborhood once familiar?

Probably no group in our urban society is so dislocated from the anchors which make life meaningful and relevant than are today's aged. We must comprehend the impact of such changes on the older individual and view him in this context if our services are to be of significance.

People Oriented Planning: Not Organization Oriented

In the planning for, and the delivery of services to the older person, we must give recognition to the needs of the aging in the family, in the home, in the neighborhood, in the community, and in the region. Today, there is an increasing emphasis, for example, upon a regional, metropolitanwide approach to facilities and services. This is not to challenge the validity of such an approach; rather, it is to emphasize, within the context of such an approach, the necessity of recognizing the unique and important relationships of the larger area to its smaller units, such as the neighborhood and the individual. There is an increasing tendency to stress the centralization of services, such as the community hospital, or the community health center, and measuring the importance of such approaches in terms of efficiency, while at the same time losing sight of the individual and his particular needs in a specific setting.

Too often, in the planning and offering of services, we have failed to recognize the dynamic, ever-changing character of human needs. Particularly for older persons, it is imperative that our health and welfare services be flexible, permitting movement among and between services.

When we speak of matching the services to individual needs of the aging, we must question: (1) whether we look at the service and how the individual must fit *its* definition: or (2) whether we view the service as a linkage to other services to meet the particular needs of the individual. For example, do we view the purchase of nursing home services as payment for a nurse? a substitute family? a "roof over the head?" What is the responsibility of the caseworker in the public agency in viewing the older client who presents the need for such a service? Is it solely eligibility and payment? Is there linkage to other societal and community resources in the development of an appropriate plan to meet the totality of need by that older person?

Many of the problems associated with the aging and their needs are interrelated. This is basic to understanding the behaviors and requirements of older persons.

CONCLUSION

We must, therefore, re-evaluate our concept of the organization of health and welfare services and their base of operation in the community, as well as their relation to the people they are to serve. We are concerned about the individual, his ability to function, and appropriate ways to intervene if he is unable to function. This implies levels of evaluation and assessment of individual situations which, in turn, means levels of services based upon evaluated need. It is vital, too, that each person who provides services be able to recognize breakdowns in our abilities to respond to the unique requirements of the individual.

Knowledge about aging is both increasing and changing. Older persons and their requirements will change with the passage of time. We will be able to measure the effectiveness of our efforts to individualize and make available appropriate services for older persons only if we gain knowledge as to the norms or usual mode of behaviors associated with aging. As we recognize and understand such norms, we will be able to translate our practice into implications for research, training, and future practice.

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PRACTITIONERS, THEIR FUNCTIONS AND SETTINGS, TRAINING NEEDS AND NEW POTENTIALS

by
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A multiplicity of professionals as well as skilled, semiskilled and unskilled practitioners serve the elderly in a variety of settings. And yet, the total number of completely different settings is minimal. The number of different practitioners is greater than types of places where they practice, and the extent to which they are found is related to both the philosophy and the basic function of the setting. For example, nurses aides would not normally be expected in a counseling-only setting. To illustrate further, the philosophy of practice shows us that few local health departments have public health social workers working alongside the public health nurse.

GENERAL BACKGROUND

Service to the elderly is a dynamic ongoing process directed at maintaining or reestablishing an older person at as full and complete level of physical-psycho-social-vocational function as possible. It involves varied types of trained personnel, operating as a team either within the same agency or among organizations, supported by public interest. The particular role of each team member varies with the setting.

Training practitioners in gerontology is quite new. Any overview of needs and potentials is intimately related to an amalgamation of scientific inquiry, empirical observation, professional conceptualization and moral judgment. A determination of what knowledge is needed, and how this knowledge is ascertained and verified, is intimately linked to philosophical judgments which set the tone as to what we believe to be important for training. The manner in which this knowledge is used is predicated on our values as reflected in the individual adaptation of those attitudes considered acceptable by our total culture and its fragmented subcultural components.

The aim is to train for the ideal, yet to relate to the practical.

SETTINGS

A brief description of places where services are rendered follows. The first description relates to settings through their source of support.

Source of Support

1. *Public or tax supported.* The theory behind this setting is that government has the responsibility for "taking care of those who cannot be taken care of elsewhere," usually because of lack of personal funds.

2. *Private, not-for-profit, eleemosynary settings.* This may be any type of not-for-profit sponsorship such as a community foundation, United Appeal, fee for actual cost of service for those able to pay, funds from religious bodies or unions or fraternal groups, among others.

3. *Private or commercial-for-profit settings.* The funds may come wholly from the persons served or partially from a third-party choice.

Each of the above three major sources of support settings invariably relate to "third-party payments," whether for an individual directly, or in a lump sum to the organization, agency or institution. The multiplicity of increased involvements becomes apparent when a third party such as an insurance company, a church fund, the United Appeal or a tax fund, pays directly or indirectly for a service performed. Further types of such payments are those made by guardians,

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persons who hold power of attorney, children of older people receiving service, and others. The importance of the source of funds also varies with the type of setting. For example, a family service agency may rely wholly or primarily on United Appeal funds; a church home for the aged may depend on money from the church, financial support from the individual patients or members of their families, or from public funds such as Medicare, Medicaid or Veterans Administration monies; a proprietary nursing home may utilize private individual funds and tax funds (public assistance) paid to the individual; a long-term wing of a general hospital may be compensated for services by third-party payments through insurances and public assistance, and from other sources.

Type of Orientation

In addition to settings as they relate to sources of support, are settings as they relate to their overall orientation.

1. *Health oriented facility.* Such a facility may be:
   a. Physician's office
   b. Local health department
   c. State mental health hospital
   d. Extended care facility or nursing home
   e. General hospital (long-term care section)
   f. Others
2. *Social work oriented agency.* Such an agency may be:
   a. A family service agency
   b. A community information and referral agency
   c. Senior citizen park programs of a public recreation department
   d. Others

While there are other orientations, the above-mentioned are the most important in terms of numbers reached. The sponsorship has a bearing on how these orientations are put into operation. If it is a sectarian sponsorship for the total community, the approaches may vary, affect the above rationale, and alter some of the content. Planning is not listed as a special orientation here, for the specific planning goals are related to each of these orientations. For example, planning for housing needs of the elderly has all three orientations—whether or not they are consciously acknowledged by the housing planners.

Type of Function

A third major description of settings relates to their ascribed functions. In other words, is the setting geared to meeting the needs of the mentally ill or those who have physical disablements or those who have difficult social situations? The listing under the heading of *type of function* is not exhaustive, but rather illustrative. Only the major function is considered. A listing by such function includes:

1. *Rehabilitation.* The institution would be the rehabilitation facility, both inpatient and outpatient, regardless of the proper name of the particular aegis by which it may be known. The proper name may be Smith Haven or the overall sponsor may be a home for the aged. Rehabilitation would relate to either physical health, mental health, or a combination of both.
2. *Counseling.* The agency purpose may be to offer counseling in regard to the best plan for the aged parent, locating sources of funds for a person, or spiritual counsel offered wherever the aged person may reside.
3. *Custodial.* The institution or residence is geared to provide living arrangements, but not necessarily nursing or rehabilitation procedures.
4. *Nursing Care.* The facility is designed to provide nursing procedures, but not necessarily rehabilitation. On the other hand, nursing care procedures may be carried out within a person's own house or apartment by a visiting nurse.
5. *Housing.* The facility is geared to provide independent living and may be one's long-time house, a specially designed house or a multiple unit apartment dwelling. No built-in services are automatically provided although they may be available. Home aids such as Meals-on-Wheels, homemakers and housekeepers would be found here.
6. *Social.* This may be found within special buildings or units of buildings in various sections of a community.
7. *Education.* Educational activity may be in the form of special retirement courses offered through varying auspices to different educational levels, or it may be an accident prevention promotion by the local Safety Council, or may concentrate on continued or new avocational/vocational goals.
8. *Protection.* Protective functions are implicit in many of the above, but because of legal involvement they are listed separately. Guardianship of the person or the estate is vital in the process of adequately serving many of our aged.

Type Related to Numbers

A final analysis of settings relates to the number of people being served:

1. *Individual "face-to-face" relationship.* This is found most frequently in a counseling type service.
2. *Group relationships.* Here, usually, we think of institutions and recreation centers.
3. *Community planning.* Overall planning to serve a community, region, State, district or the Nation is the primary consideration.

There is appreciation that at all times all three are utilized in each of the "setting types related to numbers" served, but the primary setting purpose still holds true. As a corollary, one can also think in terms of services to people in their own households, services within a group environment, and total community planning.

THE SETTING AND THE PRACTITIONER

Regardless of how one analyzes settings and their functions, two objectives are necessary to the final attainment of mutual goals. In order to plan solutions, one must first assess the nature and scope of the problems and inventory the resources available for dealing with them. The secondary purpose is to provide sound foundation for action at any planning or practitioner level by providing a uniform, comparative method to ascertain what is, or ought to be available.

Practitioners become the basic ingredient for any setting to meaningfully serve the aged. To accomplish this, both settings and practitioner must know *who* are to be served, *why* they require assistance, *what* resources are already available to serve, and *how* the required services can best be made available to those who need them.

Who

The people to be served should be identified. The way in which they are identified becomes important, such as:

1. Persons served in *public* facilities
2. Persons served in *private* group facilities
3. Persons served in *other* types of settings such as nonresident type health and welfare agencies

The particular needs of persons in any one of these three major groups are influenced by sex and age factors. For instance, female unmet needs of those 65–75 years may be quite different from unmet needs in women aged 80 and over.

Why

A *why* analysis seeks to identify the major problems the practitioner strives to resolve. Four major problem groupings to be considered are:

1. *Economic problem areas*
   a. None
   b. Temporary 'tide-over' funds
   c. Prolonged financial support
2. *Vocational problem areas*
   a. None
   b. Returning to former job or occupation
   c. Finding a new job
   d. Retraining
   e. Other
3. *Social problem areas*
   a. None
   b. Family relations
   c. Group and community relations
   d. Recreation interests
   e. Nonfamily living arrangements
   f. Personal care
   g. Other
4. *Psychological and health problem areas*
   a. None
   b. Mental or psychological residuals (limitations that remain after care has been instituted)
   c. Deviant behavior
   d. Other

What

A *what* analysis involves listing the kinds of resources necessary to meet special problems. This listing indicates whether or not a resource is available and is vital to the role of the practitioner, for the latter may alter the function of setting dependent upon the former. The potential assistance which might be brought to bear on meeting a particular need conceivably encompasses the entire range of material things, people, ideas and social institutions. Some examples of pertinent resources follow:

1. *Economic resources* to include everything from short-term repayable loans to outright gifts from public or volunteer welfare organizations.
2. *Vocational resources* to include evaluation and counseling, as well as training and retraining programs.
3. *Social resources* to include such facilities and services as church clubs, friendly visitors and civic organizations.

4. *Psychological and health resources* to involve the various professional health and psychotherapy manpower aids as well as drug therapy.

How

The *how* all of the above is made available to a community, offered through a setting to a particular person, is the ultimate responsibility of the practitioner.

THE PRACTITIONER

When we speak of practitioners, we refer specifically to those who directly minister to the needs of an older person, such as physician, social worker, nurse, therapist, pastor, among others. Further, within the definition of practitioner, we consider those who plan but do not necessarily have a consistent "face to face" confrontation with the elderly, so to speak, such as dietitian, pharmacist, community planner, administrator, and architect. Yet, it is axiomatic that there be moments of direct contact within this latter grouping.

The practitioner is affected by the community culture of what is expected from a particular setting. As a corollary, however, the practitioner also affects what the setting becomes in reality.

The Job Description

It is clear that the setting sets the tone for the job description, but the practitioner's title sets the major responsibilities. While the setting offers the "house," so to speak, it is what one is assigned to do within the "house" that assumes the greatest importance for the practitioner.

It should also be noted that different job description levels are developed differently, so that, for example, the administrator has general principles with some specific points outlining *areas* of responsibility, while a nurse's aide may have very specific job tasks. Further, job descriptions are important only as tools, for all functions not only change with time but also vary with the person. In this sense, people with the same job title may well be doing dissimilar things because of their particular adaptability.

There are various disciplines involved in serving the aged, all of which are found in serving people of all ages and many in commercial and industrial ventures of all types such as a maintenance person, a cook, a bookkeeper or a secretary. These staff need interpretation to program aspects. But it is the *program person* who is the key in transmitting and putting into practice the knowledge applicable to serving the elderly.

The practitioner cannot be assigned his functions beyond his setting, albeit each profession and each type of job suggests certain boundaries. Beyond these boundaries it may become another profession and another type of job.

But the most important aspect of all is how the practitioner, by whatever his title, sees his function within the culturally accepted role of his setting, with the full recognition that changes in roles are not only inevitable, but also gradually become recognizable.

For Professional Practitioners

In describing needs of professional practitioners, we come to at least three major conclusions:

1. The need for reorientation of a particular specialty to the field of aging.
2. The need for modification of previous and existing stereotyped professional attitudes.
3. The need for role delineation of each profession in a total team effort.

REORIENTATION OF SPECIALTY TO FIELD OF AGING

The need for reorientation of a particular specialty to the field of aging can be exemplified in every profession. For illustration only, the three professional types are singled out: physician, registered nurse and social worker.

The Physician

"The physician . . . in many ways . . . has a shorter span of patience with the older patient who is less satisfying, slower to heal, quicker to relapse, so near to death.

"He looks at the older patient with irritable eyes, recognizing human frailty and mortality for what it is." [1]

"The patient-physician relationship is a crucial factor in health maintenance. The physician can be a prime mover in motivating the individual to self-help and self-reliance. The physician must understand how the aging individual feels and behaves in this relationship. He must communicate concern and understanding." [2]

Further, ". . . we find that many of the Nation's most distinguished university medical centers have successfully isolated themselves from the growing needs of the chronically ill and disabled." [3]

The Registered Nurse

The registered nurse, who has been trained with emphasis on short-term care in the general hospital, is more often than not ill-equipped to cope with the demands of long-term care and its consequences of

intensified family involvement and growing staff attachment or disenchantment with patients. Too, the recognition that a higher percent of one's patients, compared to short-term hospital patients, will not become "well" cannot be overlooked.

"The nurse who cares for the aged must be a very special type of nurse. Not every good nurse is qualified . . . ." [4]

At a period when the shortage of registered nurses in the geriatric field is acute, one may well ponder why a standard setting facility requested the resignation of three registered nurses within a period of 18 months.

"We (nurses) should take stock of ourselves and examine our real viewpoint on aging, the aged person and death. Our own philosophy of life is bound to show itself in our work with older people . . . ." [5]

The Social Worker

Until recently, very few social workers have been interested in aging. Examples of this still reluctant interest may readily be found through:

1. Few positions advertised in professional journals.
2. Slow growth in contributors to social work literature on aging.
3. Schools of social work curricula and field placements. The first placement of students from one major graduate school of social work came in the 1940's. Schools appear to have stabilized rather than expanded.
4. Few family agencies are working in the field of aging in spite of philanthropic funding. Those who do are the unusual.
5. Few specialized total program agencies. The several in the United States are rarities.

"For social workers, one wonders whether the profession itself fully accepts its role. . . . In the not too distant past there has been real reluctance on the part of many to work with the chronically ill aged." [6]

NEED FOR MODIFICATION OF FORMER STEREOTYPED PROFESSIONAL ATTITUDES

The Physician

Some of the comments which have been made by physicians are:

'She'll probably never be out of the wheelchair." And yet, the patient went home after 3 months walking with only a cane.

"No sense to try any therapy on Mr. D. He's too old (age 86)." Yet the patient is now up, walking without any help, dressed and entertaining visitors.

The Nurse

Comments which have been heard from *private duty* nurses are:

"They're just like children—fuss over every little thing. You have to coddle them."

"I always tell her what to wear. It takes too long for her to decide. Besides she really doesn't know what she's doing."

The Social Worker

Comments made to a gerontological social worker by other social workers have been:

"How can you work with the aged? Isn't it awfully depressing and useless?"

"I prefer to work with younger adults or children. The prognosis is so much more hopeful than with elderly."

This second need-modification of stereotyped professional attitudes is recurrent. The physician who says "He's too old to try any physical rehabilitation" is no different in professional misconception from the vocational counselor who states that beyond age 60 he cannot consider a vocational rehabilitation plan. The social worker who says "I don't know why all that money was left to old people—they should have designated it for the young" is indicating a stereotype attitude of "What can you do anyway?" The nurse who says "Old age is second childhood" is lacking in knowledge based on studies which have shown that intelligence, learning ability and other skills do hold up remarkably well.

NEED FOR DELINEATION OF ROLE OF EACH PROFESSION IN A TOTAL TEAM EFFORT

The team effort has been variously described and is probably at its peak within major institutions such as Veterans Administration hospitals, teaching medical centers and State hospitals. By team effort, reference is made specifically here to staff conferences whereby all involved professions share their knowledge and come to a consensus as to the end goal to be achieved, the next steps in this attainment, and the respective roles in this process—all directed toward a particular patient.

The Professional Practitioner

The physician is often trained to work with social workers only for "charity" patients within a hospital framework. The public health and/or visiting nurse—

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much less the hospital-oriented nurse—will have little comprehension of basic social worker skills, particularly as they relate to the aging. The social worker, in turn, unless he has had a hospital setting field assignment, may not grasp the arena of the social worker on the "team." And even when he has had a hospital assignment, the social worker role may fit the traditional assignment of looking after the "charity" patient when it becomes time for hospital release without being involved in the decision to undertake such a release.

Lack of knowledge about what other professions do and discrepancy among members on the new health team concept are apparent.

There are new roles for each professional as well as futuristic roles predicted on the gigantic changes to come through our latter day legislation. As examples, two major new roles of the social worker based on the experience of Mansfield Memorial Homes, are as follows:

1. The social worker may be the key person in staff education and carry the responsibility for formal in-service training in long-term or extended care facilities as well as less formal day-to-day conferences. As a corollary, the social worker may also be the key in the development of staff education for all types of community agencies.
2. The social worker may be the key professional in both admission and discharge planning within long-term care facilities as well as carrying out ongoing therapeutic responsibilities for patients in care. Assuredly, these are already similarly assigned roles in organized and structured homemaker programs for the elderly. They also mark major changes in needed knowledge by professionals. The understanding of chronic brain syndrome behavior is not universally taught in professional schools nor its concomitant of how one relates to such behavior.

The Nonprofessional Practitioner

The same perspectives outlined for the professionals are equally applicable for others such as nurses aides, food service staff, recreational aides or public assistance workers. Their misconceptions are twofold:

1. Those to be found among laymen in general.
2. The compounding of stereotypes held by the professionals.

For many professionals, then, the training must relate to reorientation, modification, delineation and new content. Not only should these be taken into account with the nonprofessional, but the latter also has a great need for training in specific techniques. Learning how to catheterize is important for a nurses aide, for example. Just as vital is the implication presented by the public assistance worker in praising a nursing home for its "therapy work." And by therapy work, she explained she knew . . . . "They give therapy because I saw a bath lift in 'x' nursing home."

TRAINING PROBLEMS

What we train for and how we train *must* be subject to intensified assessment and evaluation and be looked upon as fit areas of scientific inquiry even as we proceed to undertake training.

Six problem areas have been especially pinpointed:

1. *Motivation.* How can practitioners accept the need for specialized training?
2. *Curriculum.* How valid and useful is the content?
3. *Faculty.* Where do we recruit trainers?
4. *Trainees.* The screening of trainees and acceptance of those with the greatest potential could be an enigma.
5. *Financing.* Appropriate funding must be ascertained.
6. *Miscellaneous.* These are the multitudinous problems, such as job placement, matching the trainer and the trainee, meeting the civil rights challenge, as well as the continuous assessment to assure that training per se does not become institutionalized, but changes with evolving needs.

Established answers do not seem to fit the emergent challenges. Objectivity in science suggests detachment in observation. But detachment by observation does not suggest divorce from humanistic endeavor.

Motivation

Motivation on the part of professionals to undertake training is multifaceted. Some professionals belong to organizations which demand a specified number of postgraduate accredited hours of content by that organization to continue to remain a member of that organization. Conceivably other professions might do likewise. For the professional, an appropriate certificate upon completion of a training course is a desired goal.

We have, therefore, developed certain workable techniques which can be used universally and modified to provide the motivational "bait" to take part in training.

Curriculum

Just as a generic body of gerontological knowledge is gradually evolving, so is there increasing knowledge being disseminated, although in a spotty and irregular manner. With some universities and direct service institutions now offering specialties in gerontology ranging from graduate degrees to inservice training certificates, it is apparent we are near a "breakthrough" in accessibility to knowledge both pertinent and teachable.

Faculty

Material is of limited use without appropriate faculty. The training of trainers is now in its infancy stage. We have learned that a faculty member of a great institution is not automatically capable of training the trainers without specific knowledge backed up by specific experience. However, professional schools, working closely with institutions and/or agencies serving the elderly, may be woven together to form an adequate faculty. In fact, one might suggest that the institutions and/or agencies, working together with professional schools, is a definite trend in some parts of our United States. This connotes the beginning of a great possible change, namely, the serving institutions taking the leadership and inviting the professional schools to join them.

Trainees

The inherent suggestion is that all professionals are automatically eligible for training. Perhaps the realities in the early period of training gestation will provide no other choice. However, the thought is promulgated here that findings from practitioners of all types be transmitted to graduate schools for consideration in *their* screening of student applicants and in *their* assessment of student development through their field assignments.

Nonprofessional screening for training poses other problems. A blanket procedure for training all employed in serving the elderly seems like a reasonable, yet momentous, undertaking. But we must turn to our researchers—working hand in hand with the trainers—to aid in the "long haul" to both assess what is taught, how it is taught, and what attributes would be the most pertinent for appropriate selection. For, ". . . if flexibility in approach to the elderly is beneficial, then applicants who have personalities that offer a rigid response to the older person should be excluded." [7]

Financing

The Older Americans Act, Social Security legislation, and the Economic Opportunity Act represent some of the newer potential sources for assistance in funding training activities. Some States and private philanthropies are also possibilities. Suffice it to say, the major problem here, at the moment, is knowing what to offer and *having it to offer* and then seeking out the potential sources of funding.

Race Relations

Of special relevance in the training process is the civil rights attitudes of the trainer and the trainee. As the national momentum to motivate the Black to be educated and trained to his maximal capacities is enhanced, and as training resources reach out to the Black, we will begin to have more Blacks in positions of responsibility such as physician, social worker, registered nurse, licensed practical nurse. This poses problems of *social distance* or the attitudes of closeness or farness, acceptance or rejection, which persons have toward each other. We may conjecture and say that in much of the United States the physician status takes precedence over Black status, but this is not necessarily true with some of the other positions mentioned above. Working under a Black registered nurse poses personal problems of varying magnitude for a licensed practical nurse or a nurses aide. The trainer must recognize that:

1. Considerable individual difference in social distance is felt by various persons toward the members of some race.
2. Regional-cultural differences such as those between Northern and Southern Whites regarding Blacks do exist.
3. Approval or disapproval of races or relationships, stemming from current stereotypes rather than actual experience, is common. [8]

SUMMARY

Training programs should include the following goals:

1. Providing an increasing number of skilled personnel to serve the aged.
2. Making the professional practitioner role more significant and the team role more meaningful.
3. Giving more and better quality service for each dollar of practitioner and research expenditure.

4. Amalgamation of training and built-in research components for continuous evolvement and assessment of training techniques and training content.
5. Upgrading the total health and health-related care for older people.

It is recognized that the philosophy of the professions has a direct bearing on the type of care which is prescribed and proscribed. This, in turn, is reflected through the methodology of training, the sensitiveness of the trainers to the local culture, and the awareness by trainers of personal norms of trainees.

The challenge of training practitioners is upon us now. Reorganization of medical and health-related resources on behalf of the elderly so as to provide such training is implied. To serve efficiently and humanely requires the amalgamation of both practitioner's experience and scientific knowledge. This knowledge serves as the base to train our practitioners.

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GERIATRIC NUTRITION*

by

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Rapid social changes coupled with population growth in the United States have increased the number of aged persons in the caseload of many practitioners—nurses, physicians, social workers, among others. It has become increasingly obvious that understanding and knowledge about nutrition as it relates to health maintenance of the aged is essential if the practitioner such as the public health nurse is to provide sound health counseling.

NUTRITION COUNSELING

New knowledge on nutritional needs is now available. For example, studies were conducted in two geographic areas of the Nation to determine community needs for nursing service based on 18 categories of potential health problems. Findings revealed that the need to modify food habits outranked all other categories; in the second study, the need for help with modified diets ranked third.[1] [2] Other reports have emphasized that in order to maintain some measure of good health and independence, the aged person requires definitive health counseling, including nutrition guidance.

Nutrition is a primary component of health counseling, whether a nurse is giving preventive health services or a social worker is helping older adults learn to live with a chronic illness or disability. Practitioners, because of their direct relationship with patients and their families, should be sensitive to the individual's needs, able to communicate with him, discover his concerns, and motivate him toward better health goals.

For example, before a nurse can counsel the older patient on nutrition, she must learn all she can about his medical condition and daily food habits. Her attitudes toward him and her own feelings about food and nutrition will markedly influence the food practice information she obtains from him.

She must be aware of the fact that the older person's food choices and practices represent a lifetime record which has been influenced by multiple environmental, emotional and physiological factors.[3] [4]

OBSTACLES TO ADEQUATE NUTRITION

Older persons are a critical group in our population and could benefit from nutrition counseling. Some of the factors that may be obstacles to adequate nutrition are as follows:

1. Limited income may restrict the purchase of adequate amounts and right kinds of food and provide for no more than meager cooking facilities and refrigeration.
2. Inadequate dentition can create difficulty in eating.
3. Appetite is usually decreased.
4. Reduced activity, increased fatigue and weakness, or living alone may affect the incentive for eating.
5. Loneliness, unhappiness and anxiety can lessen the appetite and lead to disinterest in food. Fewer active taste buds, diminished acuity of sight and smell, and lessened motor skills also may bring about a deficient intake of food.

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Other Effects of Aging Process

With the aging process comes the gradual reduction in the basal metabolic rate, slowing down of the digestive processes, atrophy of the alimentary mucosa, and possibly lessened absorption and utilization of food elements due to diminishing secretion of digestive enzymes. The transport of most nutrients may continue to be normal and good. On the other hand, circulatory disturbances may slow down the transportation of a nutrient from one part of the body to the other. Decreased renal clearance or kidney function may affect the elimination of metabolic debris from the body. Since such physiological changes are to a greater or lesser degree characteristic of "well" older adults, problems of the person with a chronic illness may be further compounded with regard to ingestion, digestion and metabolism of nutrients.

DO NEEDS CHANGE WITH AGE?

What advice can a physician, public health nurse, social worker, dietitian or related health practitioner give the older person regarding his nutritional needs? The older American has nutritional requirements similar to those when he was twenty-five years of age, except for calories. The nutritional needs should be based on the recommended dietary allowances of the Food and Nutrition Board, National Research Council.[5] These allowances usually can be met satisfactorily through selection of foods from the basic four food patterns developed by the U.S. Department of Agriculture.[6] The basic four include the following food groups: milk, meat, fruits and vegetables, breads and cereals.

Generalized Needs

How fats contribute to man's health is still a matter of controversy. Research is not conclusive enough to recommend drastic changes in the kinds of fat—saturated and unsaturated—that should be consumed. It seems reasonable that the healthy older person continue to eat the kind of fat, in moderate amounts, that he has been eating in the past. However, medical authorities indicate that persons with such diseases as atherosclerotic heart disease or a coronary occlusion would be wise to eat less fat and to substitute unsaturated for some of the saturated fats.

Protein nutrition must be watched more closely in the older person than in the younger one. Too often, the intake may be less than the recommended daily dietary allowance.[7] Many older persons do not eat enough protein because of decreased appetite, reduced activity, poor dentures and ingrained food habits.

The ill effects of hypoproteinemia become more conspicuous in advanced years. These include retarded bone and wound repair, mild types of anemia, and decreased resistance to infection.[8] To complicate matters further, the body actually loses protein during periods of inactivity, such as prolonged bedrest or immobilization due to an injury.

Individualizing Needs

Quantities of these and additional foods are dependent on the person's energy needs and specific physiological requirements. Older persons usually need fewer calories with advancing age and women need less than men, owing to a decline in the basal metabolic rate. If the eating habits of the more active years persist, the stage is set for obesity. Older persons of the same chronological age engage in varying levels of activity, and there is a corresponding variation in caloric needs. Thus advice on calories should be individualized. When calories are restricted, fewer foods high in fat and carbohydrates should be eaten, and foods should be selected on the basis of nutrient content as well as calorie count.

PLANNING THE DIET

The daily diet should include good quality protein from animal sources such as milk, cheese, meat, eggs, fish, and poultry, as well as from vegetable sources such as whole grains, dried beans and peas, and nuts. These provide an abundant amount of the essential amino acids. There is no definite evidence that protein needs increase with age. The protein intake will be satisfactory if it is planned on the basis of one gram per kilogram of body weight. The six food exchange lists commonly used for calculating diabetic diets provide a convenient guide for estimating the daily protein intake. Foods particularly high in protein are shown in the milk list and meat list.[9] [10]

It may tax a nurse's ingenuity to find ways of encouraging the older person to increase his protein consumption. She and other practitioners as noted should be able to help him select easy-to-chew protein foods and be familiar with economical sources of protein.

The relatively high prevalence of osteoporosis among the aged may be due in part to inadequate calcium and protein, together with skeletal disease and decreased secretion of hormones. Research suggests that minimal or moderate deficiency in calcium intake over a period of years may possibly contribute to the occurrence or accentuation of osteoporosis.[11] [12] [13] A good calcium in-

take which will maintain balance assists in maintaining bone structure. Milk and cheese products are sources of calcium and a good source of protein. Here again, a nurse, nutritionist or dietitian may suggest ways to use the less familiar forms of milk and milk products.

Poor appetite, faulty absorption and general weakness may reflect an inadequate intake of foods rich in vitamins. Requirements for vitamins are not increased with age. However, because of variation in dietary habits and food practices, nutrients such as ascorbic acid, B group vitamins (thiamine, riboflavin, and niacin), and vitamin A deserve a great deal of attention when older persons are being counseled about their food intake.[14 15] For example, the B group vitamins function as coenzymes in intermediate metabolism, and unless these enzymes are in good supply, the body machine will not function well. Whole grain and enriched breads and cereals as well as protein foods of animal sources provide good amounts of the B vitamin.

ADJUSTING THE MEAL PATTERN

As the digestive process slows down with age, meal size and meal spacing may be adjusted. Large and heavy meals tend to lessen utilization and absorption of nutrients. It may be better to spread the food intake more evenly through the day and avoid the three traditional meals. Many people enjoy a snack between meals; some people believe that a snack at bedtime helps them sleep better. They should understand, however, what is meant by a healthful snack.

Effect of Advertising

In his search to maintain health and to alleviate vague aches and pains and general fatigue, the older person is often "taken in" by deceptive promises of relief or claims for restoring vibrant health made by promoters of fad diets, health foods or food supplements. The practitioner who is knowledgeable about nutritive value of foods and principles of nutrition will recognize nutrition fallacies and fads and should utilize every possible opportunity to convey and interpret scientific nutritional facts in terms understandable by the older person. Guidance toward good nutrition practice is the goal.

Effect of Culture

When making recommendations for an adequate normal food intake, every attempt should be made to include and retain as much as possible the person's present food customs. Chances are that the recommended changes for an improved food intake will not be adhered to over a prolonged period of time unless consideration is given to the socioeconomic, educational, religious, and cultural factors.

To effect the goal of good nutrition takes time. Basic to counseling is as complete knowledge as possible of the foods consumed. A simple diet history form is useful for recording everything put into the mouth and swallowed. A 3-day record is preferable, but if this is not feasible or practical, a 24-hour recall of foods consumed is essential. A more accurate picture of total food intake would include the frequency—daily, weekly or monthly—of specific foods eaten, method of preparation and number of meals and snacks per day.

SOURCES OF INFORMATION

Where can a practitioner such as a nurse or social worker turn for authoritative nutrition information and nutrition consultation in the community? Many of the official and voluntary agencies employ qualified nutritionists who can provide consultative services to the nurse. The nutritionist can provide:

1. Accurate and current information about food and nutrition.
2. Techniques for appraising family and individual food practices.
3. Advice on family food budgets.
4. Information on buying, storage and preparation of food.
5. Practical advice on how patients can adhere to modified diets.

EDUCATING THE PRACTITIONER

This assistance can be provided through either individual nurse or social worker conferences or inservice education of these groups. One nutritionist who worked with professional nurses in an inservice education program made the following comment about her experiences: "When invited to attend the staff nurses' session, I was reluctant to go to all meetings because some subjects seemed totally unrelated to nutrition. Yet, regardless of the topic under discussion, the nurses invariably had questions about nutrition, and nutrition was discussed during every session."

As the need arises, the nutritionist can suggest techniques of nutrition counseling during patient visits. The nutritionist can also work with the nurse or social worker on possible solutions to complex nutrition problems of individuals or families. In addition, they can work together on content and methodology of nutrition education classes for groups of older persons. Together

they can assess and select suitable educational materials for nutrition counseling.

In an area where there are no nutritionists, the nurse or social worker may seek the assistance of a qualified dietitian in the community hospital or food industry, an instructor of nutrition in a college or university, or an agricultural extension specialist in nutrition. These persons can advise on: food needs of the older person; food purchasing and preparation; suggestions for combatting food fads and fallacies; nutrition education techniques and tools; and helping the older person live with a prescribed modified diet.

SUMMARY

The need to modify food habits among the elderly is significant. Select aspects of nutrition affect all older people, but the varied bio-psycho-cultural backgrounds of people—especially as they grow older—require individualized approaches.

The basic differentials between older and younger persons are the uniqueness of the old through their years of living and the fact that older people need less calories, albeit older women require less than men. Individualization of nutritional guidance is all important.

Nutritional counseling by various practitioners can be undertaken after the latter are trained to do so on an individual basis or through group type training.

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CLOTHING PROBLEMS OF THE ELDERLY

by

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Clothing plays a vital part in the lives of people of all ages. Whether we consider the utilitarian, the psychological, the social or the aesthetic value of clothing as the most important, clothing is intimately related to one's personal appearance and is extremely important in social relationships, regardless of age. Since personal appearance not only influences others but affects the inner person, an attractive appearance will bolster self-assurance, raise self-esteem, influence social acceptance, lift morale and be a source of personal satisfaction.[1]

Decoration of the body itself and adornment with beads, trinkets and bits of color preceded the wearing of clothes, indicating that man has sought beauty for himself. The need for ornamentation and the desire to "look good" are the apparent norms of people.

SOCIETAL STEREOTYPES

Our society has evolved a series of stereotypes about clothing and older people. Several are examined here. It is apparent that cause-and-effect relationships are prejudged.

Careless Appearance Stereotype

One of the stereotypes of aging people states they are careless about their clothing and appearance. The validity of this concept has neither been supported nor refuted. Longitudinal studies evaluating the appearance of the same persons have not yet been undertaken; measuring devices to withstand the rigors of time remain to be established; and the multiple variables such as status change, mobility, and local clothing subculture could affect the findings more than aging itself.

"Lose Interest in Clothing" Stereotype

Another of the negative thoughts about older people is that they lose their interest in clothing. On the contrary, older women, for the most part, consider clothing and an attractive appearance as important, if not more important, than when they were younger. Many respondents in the University of Iowa research indicated that older people must work harder at being attractive to compensate for some loss of physical attractiveness.[2] Havinghurst suggests that older people should dress more carefully than younger people, thereby making best use of their physical attractiveness.[3] The Iowa studies indicated older people had more time to spend on their appearance and more time to spend in shopping for clothing than when they were younger. Many also noted that they were more active socially and did more traveling in retirement years and felt the need to maintain as high a level of appearance as their associates. It also was found that older people wanted to look good so that their children and grandchildren would not be ashamed of them.[2]

Older people do maintain their interest in clothing and appearance. Any decrease in standards of dress and appearance comes very late in the later years due to physical or mental health loss or to lack of money. An older person who neglects his appearance will be judged more severely than younger people, and such judgment will be age-related, while a younger person's carelessness about his appearance will be attributed to something other than age.[4]

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Society Inspired Attitude of Self Stereotype

It is likely that an attitude such as, "I'm old, nobody cares about me or how I look," has much more to do with lack of effort spent in caring for one's self and clothing than physical limitations for some aging people. Those who work with older people have a responsibility to keep prodding and encouraging them to maintain a good standard of dress and grooming.

One of the greatest spiritual needs of people is the admiration of their fellow men and women.[5] It may take some thoughtful analysis to find something on which to base a compliment, but everyone has some feature which can be praised. Compliments are morale building, they let a person know that someone cares enough to notice him, and they provide some impetus to maintain a standard.

Demonstrations conducted in mental hospitals show the therapeutic value of clothing, grooming and approval of others. This approach, begun with mental patients who were scheduled to be released from a Napa, Calif., hospital, was also extended to other patients whom doctors had not been able to reach previously. Because of the positive results, this approach spread to hospitals in other parts of the country.[6 7]

Stereotype by Service Professionals

Social workers and other professionals need to be careful that they themselves do not subscribe to the negative attitude that it makes no difference how older people look. Those who require health and social aid have suffered the indignity of not being able to care for their own needs; they are old in a youth-oriented society; they no longer have the rewards of a job and its associations; and they may have lost the security, the affection, the companionship and the ego-support of some of their family and friends through death, moving, or detachment. To compensate in some measure for these disheartening conditions, they especially need to have cheerful, comfortable, properly fitted, clean, and suitable clothing.

In addition to having attractive, suitable and becoming clothing to maintain a good appearance, it is important to have clothing care, hair care, cosmetics and toiletries. Those who serve older people should be cognizant of this. Consideration should be given to providing these for older people; perhaps families who are not able to assume full care of their aged relatives could be encouraged to provide gift certificates at a beauty shop, a barber shop, a dry cleaner or a podiatrist. Foot care may seem to be unrelated to personal appearance, but those who cannot walk comfortably cannot appear at their very best.

An older person who appears in out-of-date or unsuitable clothing or who is dirty or unkempt may not be respected and therefore not served in a professional manner. Older people do not want to be treated in a patronizing manner. They want what everyone at any age wants: to maintain self-respect and personal dignity. "They do not want to be cared for—they want to be cared about; they do not want to be isolated—they want to be integrated into community life; they want to perform tasks within their individual capacities without encountering preconceived notions that age is a deterrent to being useful. They want to exercise their right and responsibility to remain independent and self-directing as long as possible." [8]

FACTORS AFFECTING CLOTHING NEEDS

There are varied aspects to consider in recognizing clothing needs of aging people. Among these are social relationships, economic factors, physical changes and safety needs, and availability of clothes.

Social Activity

"What our retired elders yearn for more than anything else is involvement. They are crushed with the feeling of no longer being wanted, useful or important to others. They have been stripped of their value—and so, of their dignity as human beings." [9]

To make social relationships rewarding, older people need to have clothing which is similar to that worn by others in the group as well as clothing which is best for them as individuals. Being well dressed and well groomed is essential for group participation at any age, but it is especially important for older people who may feel that younger people do not welcome their participation. Many older people have to enter into new associations, and an attractive personal appearance can be reassuring.

Economic Factors

Less money is spent for clothing by older people than by young people. Rather than indicating that clothing is less important to them, this lower expenditure may be due to one or more of the following factors: clothing expenditures have to be restricted in favor of use of funds for other purposes; older people buy more conservatively styled clothing which can be worn longer; needs for clothing decrease because of less work and social activity; clothing lasts longer because of this decreased activity; clothing is received as gifts from family and friends; and/or clothing is

purchased at rummage sales and secondhand stores. No matter how clothing is obtained, if it is to serve its full purpose, it needs to be suitable, attractive, comfortable, properly fitted and clean.

Physical Changes

It may be necessary to make provision for some of the changes which are likely, in varying degrees, to accompany aging. There is likely to be a loss in stature due to changes in the spine. There may be an increase in weight, but even without an increase in weight, there is likely to be an increase in the size of the waistline. There may be stiffening of the joints making it difficult to manipulate small fasteners or to get one's clothing over the head.

There may be a reduction in the caliber and efficiency of the blood vessels in the skin, resulting in the body's inability to adjust easily to temperature changes or to tolerate extremes in temperature. However, it was found in the Iowa City study [2] and in Watson's later study [10] that women did not consider warmth of great importance in the selection of their clothing.

Strength loss and easy tiring may make it necessary for older people to wear lightweight clothing. This same strength loss and easy fatigue makes dressing and undressing strenuous activities for many older people. This may mean that older people may be tempted to spend the day in lounging clothing because they may lack the energy to change their clothing and clean up during the day. It also indicates a need for clothing which is easily donned and removed.

Skin is likely to become thin and sensitive to irritation, calling for the use of soft, smooth fabrics and for clothing construction which is free from rough, bulky, or tight seams which might chafe the skin. This same skin sensitivity also makes it important that all detergent residue be carefully rinsed from clothing in the laundering process.

Physical changes come gradually and some of the changes make older people more, rather than less, attractive. Graying of the hair is usually the first and most obvious of the aging changes, and in many cases, this is a positive change; many people are more attractive with gray or white hair. There may be changes in skin tones which will enable older people to use colors which were not flattering earlier, but they may also find that some of the colors formerly worn are no longer becoming. Lines and wrinkles are not always a negative change; they may give a pleasing character to a face which may have been uninteresting with the smoothness of youth.[11]

Safety Needs

It is not known to what extent clothing is a factor in falls suffered by older people. It seems likely that a fall could be caused by clothing that is too long or too long in front when a person stoops or leaves a robe unfastened. Loose, full garments that might catch in a door as it closes could easily throw an older person off balance and cause a fall. Untied shoelaces are an annoying problem to people of all ages, but they are a real hazard to older people, as are shoes and bedroom slippers which do not fit or are slippery on the bottom.

Burns are another source of serious injury to older persons. A recent report states that there are approximately 2 million burn injuries each year; that those caused from clothing being set on fire account for 40 to 60 percent of such burn injuries, and that 55 percent of the deaths caused by clothing fires happen to youngsters under 9 and persons over 75.[12]

The fire hazard of a fabric consists of the ease of ignition, the rate of flame spread, the amount of heat liberated and, in some cases, the dripping residue which causes severe burns when it adheres to the body. Varying levels of flammability are inherent properties of all fibers, but some of the acetates and rayons are more flammable than the other fibers. However, fabric construction may be even more important than fiber content. Sheer fabrics and fabrics with brushed, napped or pile surfaces, particularly those with loose base construction, are serious fire risks. Garment construction is also a factor, with long loose sleeves being the worst hazard.

Wearing a sweater or robe over the shoulders so that the sleeves dangle is a common practice and a dangerous one if a person is working at a stove. Fires in which older men are burned often are caused when a pipe is put into a jacket or robe pocket.

Producers of man-made fibers have been successful in putting fire-retardant substances into their fibers before spinning so that their fibers will meet the flammability standards of the Flammable Fabrics Act, but they have not produced a fire-retardant fiber in commercial amounts by this method.

Clothing Availability

Older people prefer to shop for their own clothing. This may be a factor in their retaining a higher degree of interest in clothing and appearance and in maintaining their feeling of independence. Inquiries have shown that older people would like to have helpful, courteous, genuinely interested salespeople; that they would like well-lighted stores, with easy access from one floor to

another, with good selections from which to make their choice; and that they would like a shopping situation in which they could fulfill their needs without spending too much time and energy.

However, the elderly often are handicapped by lack of funds, lack of transportation to stores and lack of energy to shop. They also may be handicapped by failing eyesight, loss of hearing or unsteadiness on their feet. They face the prospect of coming in contact with people who are impatient when it takes longer to make a decision or complete a purchase transaction, or with people who ignore older persons or show by their actions that they would prefer to help younger customers.

The clothing needs of older people cannot be defined clearly. This has placed manufacturers and merchandisers of clothing in somewhat of a dilemma. On the one hand, they are criticized for failing to recognize the older segment of the population and for failing to meet their needs. On the other hand, they find that many older people do not wish special identification or to be set apart as a group. Advertisers also have found a puzzling situation. They have found that emphasis on age or infirmity often results in stubborn sales resistance, but they also are finding, as Burnett did,[15] that older people are not influenced by advertising because of the use of young models.

CLOTHING IN INSTITUTIONS

Two basic types of institutions are mentioned here to indicate specialized clothing aspects: the retirement home and the nursing home.

The Retirement Home

There is a definite awareness of clothing of other residents and there is a feeling of need to be dressed like others in the retirement home.[10] Massey concluded from her study that living with others in a retirement home appeared to stimulate a greater understanding of the importance of appearance to an individual's well-being.[13] There are activities in retirement homes which bring the residents together and provide occasions for "dressing up," and many consider it important to be well-dressed in the dining room. Results of studies in retirement homes show there is a high interest in clothing and appearance.

The Nursing Home

Nursing home patients require a great deal of care and it is difficult to keep patients looking their best. However, a high level of well-being may be seen when patients have attractive and colorful garments and are well-groomed. Visitors and volunteers relate to patients who are well-groomed and attractive.

Aging people should be accorded the dignity of a good appearance when they no longer are able to care for their own needs. During a visit with a class to a nursing home I noted the unkempt condition of one old woman—her hair very obviously had not been combed that day, and her clothing was equally disheveled. She was quite old and blind, but she carried on a lively conversation with members of the group. The students remembered her as a bedraggled old woman, rather than a brilliant scientist during her active years. "Some provision should be made for grooming therapy, either by having facilities and personnel in the home or through special arrangements with a local beauty shop or other resources appropriate to the needs of the patients in the nursing home. Minimum care for women not able to take care of their own needs should be daily combing and arranging of the hair and shampooing as needed. When people see each other well-groomed, they all benefit in a therapeutic sense." [14]

Keeping clothing on some disturbed patients is sometimes a problem. A coverall sort of garment which mentally retarded children could not remove has been designed; perhaps there is need for something of this sort for particular older patients who constantly take off their clothes.

Nursing home administrators need to be sure that their employees understand the importance of a patient's appearance—to the patients themselves and to their visitors. Families need to be encouraged to provide cheerful, attractive clothing for those in nursing homes. Nursing homes report they often are surprised with some of the dreary, castoff clothing brought by families for patients to wear. In some cases, this may be all that can be afforded, but in far too many cases, the importance of cheerful clothing is not appreciated. Manufacturers need to provide gowns, bed jackets and robes that are pretty but do not require special care in laundering. Families cannot expect nursing homes to give special care to fragile, fussy garments for patients unless they are willing to pay for the special handling involved.

COMPARISONS OF CLOTHING FOR MEN AND WOMEN

There may be specialized needs which must be met in clothing for physically handicapped older men, but these needs are not necessarily age-related. Handicapped persons of all ages and both sexes need specially designed clothing to accommodate body deformities;

clothing with specially placed openings to put on over braces and other supportive devices; and clothing with pockets and protection for urinal bags and similar appliances. The Cleveland Center for Vocational Guidance and Rehabilitation Services has done exceptional work in designing, constructing and distributing garments to meet the special needs of handicapped persons of all ages,[16] with consideration given to the design and manufacture of lingerie and foundation garments for handicapped women,[17] and to design and manufacture of clothing for disabled men.[18]

Clothing for men

The pull of conformity has been greater for men than for women, and apparently men are uncomfortable in a social situation if their clothes are not like those worn by the other men in the group.[18] Men's clothing has not been as subject to the whims of fashions as women's and has not been as widely publicized in features and advertising in magazines and newspapers. However, Horn points out that the fashion cycle is there; that shoulders and lapels progress from wide to narrow; and trousers move from tapered to full. She adds that the fashion cycle for men's clothing moves more slowly because men's dress is more deeply rooted in custom.[19]

Horn also notes that apparently there are norms of clothing behavior for men at different age levels. ". . . A man in his forties is expected to be dressed in good taste and well-groomed, but to flaunt in sartorial splendor like a peacock is obviously inviting trouble! Men in their seventies are expected to pay greater attention to their physical comforts in clothes, and their overall appearance is anticipated to be somewhat relaxed and subdued. An older man who prefers a more fashionable image than the norm allows runs the risk of being typecast as a 'lecherous old goat'." [19]

Whenever men's clothing has been mentioned in discussions of the problems of older people, it has been reported that men do not encounter problems in obtaining clothes, other than those problems of money, transportation and energy to shop. The ease with which older men can find clothing is doubtless due to the flexibility of the sizing system for men's clothes which takes into account the differences in body build. The ease of finding clothing may also be due to the fact that men's clothing comes in several pieces and that alterations are relatively simple.

It has also been suggested that older men are likely to wear more casual clothing after retirement. This may be due to the fact that there has been a trend toward the use of more casual clothing by men of all ages and that casual clothing is likely to be more comfortable, lower in cost and easier to care for. Casual clothing also may be more colorful, which may seem more cheerful or be just a pleasant change from white shirts which may have been necessary for business wear.

Because men's clothing styles have not changed rapidly, men often are able to wear for a long time the clothing which they had on hand at retirement. It also means that men who buy their clothing in second-hand stores or at rummage sales are not as likely to be faced with the prospect of completely out-of-date clothing as might be true of the women's clothing. Even so, the care of clothing is a problem since this is a task which many men were not accustomed to doing.

Clothing for Women

There is little reason to believe that older women feel any different about clothes than younger women. As noted by Odlum, "Clothes mean much more to women than men. They often mean the difference between success and failure. The right clothes mean an added zip to life, a heightening of the woman's belief in herself, youth, gayety, and happiness." [20]

Older women are more likely to consider it necessary to wear a hat than will younger women. This reflects the more formal approach to dress when today's older women were young. A hat does lend the feeling of dignity to an older woman's appearance and makes her costume more complete. Older women have indicated that they have trouble finding hats that they consider suitable.

Housedresses are considered an important part of most older women's wardrobes, but they have reported difficulty in finding attractive housedresses. They want them to be cheerful, attractive, designed for easy body movement, easy to get into, have pockets, have sleeves which cover the upper arm, and be easy to care for. Yet older women consider the attractive appearance of a housedress more important than ease of care. Many older women want their housedresses attractive enough that they can be worn all day. Older women have quite typically changed their dresses after their housework was done and many continue to do so even though they may do little housework.

Older women often have reported difficulty in finding shoes that are attractive, give needed support and fit properly. In recent marketing research conducted to learn if there would be acceptance for products labeled "Golden Years," it was found that people appeared to be satisfied with food, cosmetics and clothing and felt no need for special products. However, on closer prob-

ing it was shown that there was dissatisfaction with the style and fit of clothing, and more than half of those surveyed did have problems in obtaining shoes.[21]

Many older women give priority to fit and style in the selection of their good clothing. Comfort, price, ease of care and warmth were considered to be of less importance. There appears to be no real agreement on the neckline preferred by older women although there is preference for elbow length or longer sleeves which cover the sagging flesh of the upper arm. Gored skirts are preferred by many older women as they provide more sitting allowance and knee coverage, but many indicate that they prefer the appearance of straight skirts. Front openings are considered more convenient for older women, but many indicated that they thought garments with back or underarm openings had more style and quality.

It is quite generally agreed that clothing is not designed with older women in mind. It is sized on standards based on the measurements of younger women so that the waistlines are not large enough. During the recent period of very short skirts, older women have had difficulty finding clothing that they consider a suitable length for them. Small older women have a hard time filling their clothing needs, since the sizes they need are for children and the styles are unsuitable. Many older women who need small sizes wear skirts and blouses which come closest to meeting their needs.

SUMMARY

Older people—rich and poor, male and female—need to have attractive, cheerful, comfortable, properly fitted and clean clothing. They need clothing which makes them as attractive as possible so that they may have the satisfaction and ego-support of knowing that they look their best. Although Hawes wrote in 1942 about there being a great deal of personal insecurity, her suggestion that clothes can give people the psychological protection which an unfriendly world fails to offer,[22] seems applicable for today's older people who have social, health or income problems.

Older people need to be dressed in a manner which preserves dignity, maintains self-respect and allows for socialization. As Ralph Waldo Emerson pointed out in his "Social Aims," being well dressed gives a feeling of inner tranquility—a basic necessity for all, and poignantly applicable to aging people.

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SHELTER FOR OLDER PEOPLE

by
Fern M. Colborn*

Although society has lengthened the span of life, it has not yet determined how the added years can become as meaningful to those persons involved as were the earlier spans of life. "The aged are a very varied and diverse group. They have every kind of need, they have every kind of problem, they are everywhere. They also have every kind of housing problem and every kind of housing need." [1] Indeed, life patterns change considerably in the latter span of life.

Recognition of the differences among the aging is an essential first step in the shelter program. These differences must be understood not only in terms of people as individuals but also with regard to localities, sub-cultures and racial and ethnic differences. "Thoughtfully developed housing, in keeping with local characteristics, can be and often is the core from which all other efforts of the community to provide independent, active living during life's third span should proceed. Programs in health and income maintenance, retraining for employment, continuing education, recreation and social activities, indeed much of the work in many fields of gerontology, may come to little if the basic security of the 'right' home—right in size, safety, design and location—is not available at rates reasonably consistent with ability to pay." [2]

LIVING ARRANGEMENTS

Since shelter is related to the size and character of the population to be housed, many factors must be considered.

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Background

Of the approximately 20 million people aged 65 and older, we find a ratio of 134 women for every 100 men. This group makes up 9.5 percent of the total population. The projection for the year 2000 is for over 28 million persons to be in this age bracket, and the ratio of women to men will be approximately 150/100. The proportion of the elderly is expected to stabilize at about 10 percent of the total population.

Life expectancy at birth is 74 years for females and 67 for males. This is an increase from 47.3 years (average for both sexes) that prevailed in 1900. Life expectancy for women is still increasing faster than for men. Whereas the trend of the general population is toward an increase in young people (half are less than 28 years of age), the older population is getting older (half in this group are more than 73 years of age). Thus, 62 percent of the 65 and older population fall in the age group 65–74, while 32 percent are 75–84 years of age, and 6 percent are 85 and older.

One out of every four persons 65 and older lives in the four most populous States—California, Illinois, New York, and Pennsylvania. Twelve States have an unusually high proportion of older persons: Florida 12.7 percent; Iowa 12.4 percent; Nebraska 12.3 percent; Maine 11.7 percent; Missouri 11.7 percent; South Dakota 11.7 percent; Kansas 11.3 percent; Massachusetts 11.3 percent; Arkansas 11.2 percent; Vermont 11.2 percent; New Hampshire 11.1 percent; Oklahoma 11.0 percent.

Almost one-third of all older people live in central cities of metropolitan areas; 28 percent live within metropolitan areas but outside the central cities; the remaining 40 percent live in non-metropolitan areas, primarily smaller towns and cities. Less than 6 percent of the elderly live on farms.

Today's Aging

What are the living arrangements of today's elderly? Out of every 100 older people, 81 head their own households, of whom 48 are husbands or wives in husband-wife families, 22 live alone, 8 head families without a spouse, and 3 have non-relatives living with them. Of the 19 out of 100 who do not head their own households, 14 live in the home of a relative, and 5 are institutionalized. Moreover, the proportion of the elderly who own their own homes is about 70 percent. This proportion is somewhat higher than for younger people. However, more than 19 percent of the 16 million housing units where senior citizens live may be classified as substandard; by contrast, only 15 percent of the households in which there are no senior citizens are substandard. More than three-fourths of all housing occupied by elderly persons was built prior to 1940. Nearly half of all the elderly live in two-person households: three-fourths have children, one-half of whom do not live in the same household; and one-fifth have no children.

In general, the money income and assets of the majority of the elderly are too low to permit the purchase of standard housing in today's market. The fact that the majority live in standard housing relates to their own thriftiness in an earlier day, and is partially explained by the fact that most elderly persons live in the older houses. However, keeping up an old house is usually a financial burden, and the physical strain is often more than can be handled.

The great majority of elderly persons live independently. In one of the Cornell University studies, it was found that 7 out of 10 persons age 65–74 did everything without help, and that after age 80, 6 out of 10 did everything without help.[3] Over one-third had not given up any activity, one-fourth had given up jobs, and one-half had given up certain heavy work. Those persons who lived in their own households had given up less than those who lived with others.[3]

Some people maintain that living in one's own home does not constitute independence, that one is independent only if the whole span of economic, social and physical life is under his control. This view does not recognize that in all stages of life, independence is a relative matter. The various housing programs of this country, both public and private, are directed primarily toward those elderly persons who are able to maintain independent living, using such social and economic resources as are available to them. It is only when an older person becomes feeble or sick that protective arrangements represented in congregate living are considered desirable. Living in age-segregated apartment houses, since each household operates independently of others, can be assumed to be independent living. The important factor is that the persons involved have the ability to make the choice as to where they will live.

Tomorrow's Aging With Today's Problems

In recent years, as efforts to improve the general environment of community life have been stepped up, the elderly have experienced considerable disruption in living arrangements with resultive personal trauma.

Society is anxious to rebuild the worn-out areas of our cities; industry must expand to meet needs; universities must prepare for the population explosion; and highways must be provided for the transportation of all. Housing programs have not kept pace with these expanding needs of society, and thus there are not enough housing units available for use in needed relocation of families and individuals.

Moreover, until very recently, it has been public policy to give attention only to the physical needs of the household to be relocated, and this has led to increased isolation for old people as they are moved to strange neighborhoods. It has also meant an adjustment in personal finances that has resulted in less money for food and medical care.

Too often, new housing developments have been built without regard to distance from stores and churches, or without a plan for transportation to such. Further, by deliberate design, community improvements have been in those parts of the cities where the lowest income families live. This has meant that a great many older persons already relocated or threatened with relocation are in no position to provide themselves with "good housing" without considerable subsidy. This subsidy has not been planned and has not been forthcoming as rapidly as the physical improvements.

Many elderly who live in their own homes and have kept them in good repair suddenly find their house is in the path of a new highway. The value of the house is not sufficient to buy another house. This has affected the nonwhite population to a far greater degree than the white population.[4] Although improvements have been made in public policy, this problem has by no means been solved, and it remains one of the points for action. Since the social worker, perhaps more than any other professional, is likely to be in direct contact with these families, a special responsibility rests upon his shoulders to actively strive for a solution to this problem.

Whether relocation of an elderly household is necessary because of some outside reason as stated above, or because of the conditions of the house, or because of physical or social needs of the individual, it should be recognized that social work counseling has a special contribution to make in helping individuals to adjust to necessary change. Older people can and do accept and develop new relationships. It is to be recognized that older people are much more capable of change than is generally recognized.[5]

Since there will be numerically more aging persons in the future, it is clearly apparent that more housing units will be needed, particularly in view of the existing shortage of housing. Subsidy, both directly for housing and to the elderly themselves, will be essential in view of the constant rise in prices. Continued improvement in relocation policies is essential. An increase in counseling service and other auxiliary services could result in relocation becoming a positive experience for elderly citizens.

USING PRESENT KNOWLEDGE TO IMPROVE SHELTER

In planning housing for independent living by the elderly, it is important to use the knowledge that exists as well as continue the search for new knowledge. We have splendid examples of application of existing knowledge to design and services both in the public housing program and in the nonprofit field, but too often these have been disregarded at the local level.

Little is known about housing management for the elderly and how it differs from general management of any housing development, and what is known is frequently disregarded. There is some information regarding site selection, and again it is used minimally. Research towards improving housing for the elderly who live in rural areas is almost nonexistent. With one-third of all older persons living in rural areas, it can almost be said that these people are the forgotten third.

Design Related to Use of Time

The first approach to any housing design is how that building is to be used. It is therefore important to know how the elderly spend their time. Wherever possible, this knowledge should, of course, relate to those elderly persons who will probably occupy the housing units. It is likewise important to recognize that how time is spent has a direct relationship to education and social class.

The Cornell study indicated that the elderly engaged in the following activities (listed from highest to the lowest percent) : watching television, visiting, reading, napping, shopping, gardening, listening to radio and records, walking, entertaining, rides and outings, church, and club. In terms of activities most enjoyed, visiting received the highest score followed by television, then reading, then gardening, with shopping, rides, church and club given equal importance.[6]

Design Related to Health Changes

Physical and emotional changes which occur relate primarily to decreases in vision, hearing, and mobility. "Today it is recognized that although persons are apt to have some form of health problem as they grow older, such problems are usually not incapacitating until very old age sets in. And while it is true that the average elderly person is confined 5 weeks of the year by illness or injury, he is able to lead a comparatively active life during the other 47 weeks." [7]

The common denominator for older persons could be summed up in the following statement: "I want to live near family and friends, near the store and near my church. If I cannot walk to these places, then I need bus service too." Studies of the subject confirm that statement. There is some difference between social classes: the middle class tends to travel longer distances and is not as dependent upon friends and relatives being as close at hand as has been found to be true of lower income families. In general, people make fewer friends as they grow older and depend more upon old friends and neighbors. Older people seem to expect family members to perform certain tasks such as taking them to the doctor, looking after business matters, and providing the pleasure that short visits by young children give. For companionship, however, the elderly tend to rely upon their peers, both among relatives and friends. These observations should give guidance to those who are selecting housing sites and, if followed, could prove helpful in meeting certain needs of older people.

If visiting peers is the major enjoyable activity of the aged, this could mean that the living room and kitchen should be in close proximity. Since there is physical change in joints and muscles, steps have been eliminated in housing for the elderly. Where ramps are substituted, it is important that there be almost no visible slope or these become worse hazards than steps. With lessening vision as age advances, both light and glare take on a new significance in planning all the rooms of the housing unit. Since hearing is often impaired, noise control and soundproofing can assist in the hearing process. All surfaces must be nonskid,

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both inside and outside of dwellings. Corners can be rounded to avoid bad bumps; cupboards, kitchens, and bathrooms can be planned with safety and health needs in mind.

It should be pointed out, however, that all housing should not be built for those who must live in wheelchairs. For example, it should be possible to erect kitchen cabinets on brackets at normal heights; then, if an elderly person becomes one of the relatively few who must live independently in a wheelchair, it would be a simple matter to adjust cabinet, sink and stove heights. Electric outlets should be in the wall at a convenient height for all rather than in the baseboard. Controls of any kind throughout the house should be readily turned on and off. In all situations, controls should be placed in positions where their use does not represent a hazard. Electric stoves may give less danger of fire than an open gas flame. Bathrooms should have grab bars and benches, and both should be placed at proper heights and locations. The stool should be of a proper height or else be installed on a platform.

Management "Know How" in Design and Operation

The housing manager for housing developments for elderly people must possess the knowledge of any manager regarding building maintenance and business management, and, in addition, be aware of community resources that he may use as the occasion demands. He must have personality traits that include unusual patience, the ability to understand situations, a friendly and helping hand, and a mind interested in study and research. He should also have special knowledge of the aging process as it affects building and equipment design as well as interrelationships.

Often it appears that someone has gone down a list and checked off items that should be included, and then installed the same without any regard for their use. A visit to a laundry room in one such project revealed the usual automatic washer and an ironing board. However, the room lacked a table, a chair, or a laundry cart, and it was a dark, small, inside room that one would wish to avoid whenever possible. In addition, because it was placed off a back corridor, people living in the development expressed fear about going to use it.

In another development, grab bars had been installed by every bathtub—but these were so located that they could not be reached from the tub while sitting, nor were they of any aid in getting in and out of the tub. This can be contrasted to other residences where grab bars were properly placed, and which had a cheerful laundry room with outside light, all equipment needed for laundry, plus rockers to encourage the tenants to socialize while taking care of their laundry.

Rural Considerations

Since 40 percent of the elderly live in nonmetropolitan areas, special attention should be directed to their needs. As conditions have changed and the youth from rural areas have flocked in increasing numbers to the cities in search of employment, a rising proportion of the elderly are being left in the smaller towns and cities without close relatives nearby. As they grow older and cannot continue the hard farm work, many farm dwellers move into the villages. If standard shelter is considered to be the right of all, this group of the elderly should be given particular attention.

Not only do rural areas have substandard housing in substantial numbers, but the elderly who live in these areas are without an effective lobby to represent their needs at points where public policy is determined.

Site Location

Whereas a number of units for the elderly may be located in the downtown areas of cities, there is also need for housing for older persons in various sections of the community, with attention given to the desire of friends and older relatives to live within easy access of each other and to required community services.

GOVERNMENT PROGRAMS FOR HOUSING THE ELDERLY

Some States have provided funds to add to the housing supply for the elderly, but by and large, the bulk of such housing money comes from the Federal sources. There is an increasing trend for States to provide technical assistance to local communities so that they can most wisely use the Federal aids available. Some of the States with special programs are California, Connecticut, Massachusetts, New Jersey, New York, and Pennsylvania.

The Federal Government entered the housing for the aged field in 1956. The Housing Act of 1956 specifically authorized the financing of dwelling units especially designed for the elderly, both through the low-rent public housing program and FHA's section 207 multi-family mortgage insurance housing program. The Housing Act of 1956 for the first time permitted single elderly persons to occupy public housing, whereas previously a family had been considered a minimum of two persons, blood related. In the years since 1956, Congress has further liberalized and expanded housing programs for the elderly.

The Department of Housing and Urban Development currently administers a wide and varied array of programs which provide financial assistance to public and private sponsors for the development of rental housing specially designed for senior citizens. These programs vary primarily on the basis of the type of financing, sponsorship, and the income group which will occupy the housing.

The low-rent public housing program provides housing for the lowest income group; the direct loan program is utilized by various sponsors to build housing for those with lower-middle incomes; and for the elderly in a wider income range, the FHA section 231 mortgage insurance program is available to both non-profit and profit-motivated sponsors.

The Housing and Urban Development Act of 1965 also permits housing for the elderly developed under the FHA section 221(d)(3) market interest rate program to be eligible for rent supplements on behalf of low-income occupants. Eligible sponsors include private nonprofit corporations, cooperatives, and limited dividend mortgagors.

Another new financing method for the development of housing for lower income senior citizens is the new FHA section 236 program included in the 1968 Housing and Urban Development Act. This program, available to nonprofit groups, cooperatives, and limited dividend entities, provides interest-reduction payments on market rate mortgages. These payments, which can reduce effective interest rates on mortgages down to as low as 1 percent, are intended to help many lower income families to afford good housing.

The new act also includes a program which authorizes HUD to make 80 percent interest-free loans to nonprofit sponsors of low and moderate-income housing, including housing developed under section 202 and section 236. These loans are available to cover costs such as those incurred for preliminary surveys, market analyses, site acquisition and mortgage commitment fees.

Specific details on these programs can be obtained by writing to the Department of Housing and Urban Development in Washington, D.C.

A much smaller-scale program, administered by the Department of Agriculture, provides insured rural rental and cooperative housing loans to build, improve, repair, or buy rental or cooperatively owned housing for rural residents with low or moderate incomes and for senior citizens.

Effect of Government Efforts

From 1965 through the end of 1968, approximately 270,000 dwelling units specially designed for the elderly have been approved under the various senior citizens housing programs currently administered by HUD. Of the 270,000 dwelling units, approximately 152,000 units were completed. When all of the units approved through 1968 are completed, it is estimated that they will house approximately 350,000 senior citizens. While on the one hand, this can be viewed as satisfying progress, on the other hand, when this number is related to the total number of the elderly, and when it is recognized that 3.6 million of the elderly live in substandard housing, it can be regarded as making only a small dent in the total problem.

Dr. Wilma Donahue has reported on a study at Lurie Terrace in Ann Arbor, Mich., built under the Section 202 programs. She cites examples of elderly people who either rediscovered or found for the first time a whole new way of life that was satisfying to them as persons, and, in addition, gave them an opportunity for new and unique contributions to their community. Conversely, for one woman in this project, the entire experience of moving into new surroundings with its new demands was overpowering and she was unable to make the necessary adjustments.[8]

Dr. Frances Carp in her study of the occupants of Victoria Plaza, San Antonio, Texas (low-rent public housing, especially designed for the elderly) found that "changes consequent upon moving to Victoria Plaza were obvious in all measures of satisfaction, attitude, life style and adjustment." These elderly persons were consistent in their movement in the direction of "good adjustment" and continued in their enthusiasm. In view of the circumstances and problems that this group had left behind them, the impact of a good environment upon the later years of life is not to be minimized.[9]

CONGREGATE LIVING FOR THE ELDERLY

The intent here has been to relate shelter to independent living for the elderly, since this is a decided trend of the times. At the same time, congregate living arrangements for the elderly represent a subject area of increasing importance for the elderly. To deal with it adequately suggests a special paper on the subject.

As important as the appropriate physical facility for whatever the type of congregate housing may be, whether the facility be a nursing home, a hospital or a home for the aged, the most significant factor is the efficiency of the staff—their training, knowledge and

understanding of the patients and their role in relation to them. This is documented by various writers on the subject.[10]

RETIREMENT COMMUNITIES

Another type of shelter for the elderly that has become popular is the so-called Retirement Village, planned to provide for independent living in small houses or apartments, and for the various stages of aging between this and the nursing home in a community where one may spend the rest of one's days. Some of these communities accept persons as young as age 50 and others have a minimum age of 62 for admission. The range of accommodations include not only small houses and apartments but also studio apartments, single rooms, dining areas, common rooms for sociability and entertaining, lounges and other community rooms and minimal health facilities.

Some of these villages have a nursing home as part of the plan and take care of all health problems except those requiring hospitalization. These communities, in effect, are supplementing the previous homes for the aged which were developed in another era. Like the homes for the aged, these villages are frequently under the sponsorship of a religious group. In addition, many have been built by private enterprise and are so operated. Most of the groups that sponsor such projects use a combination of the various government types of financing that have already been described.

OTHER SERVICES

Regardless of the type of living for older persons, services not to be overlooked include transportation, stores, churches, barber shops and beauty parlors, mail service, public telephone, newspapers—all of the ordinary things that make life normal and that are too often overlooked by planners.

CONCLUSION

Meeting shelter needs calls for close teamwork among all concerned individuals and organizations, namely the family, the social worker, the church, the sponsor, the physician, the lawmaker, the architect, the manager, and most important—the older person himself.

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HOUSING THE AGED: PLAN FOR MOBILITY

by
Edith E. Graney*

Mobility in the community and within one's own dwelling is essential to a feeling of independence for an elderly individual. As noted by Dr. Sidney Katz, there are several common aspects of aging that tend to limit the mobility of elderly people. These factors often operate together to lessen a person's ability or inclination to continue former interests and activities or develop new ones.

There are many possible accommodations and adaptations the older person and the community can make to reduce these difficulties, to increase mobility, and to provide the older person with access to a richer and more varied life. How to maintain mobility through housing for the aged is the focus of the content to follow. While the material here is primarily drawn from studies by the Minneapolis Housing and Redevelopment Authority, it is noted that the principles of mobility are also applicable to all independent living residences and apartments. Certain specifics, such as the import of public transportation, for example, may not be as vital for older people with resources greater than those residing in public housing, but nevertheless, would be of some significance to all persons affected by decreasing mobility.

LOCATION

In the selection of new sites for construction of housing for the elderly, location preferences of elderly applicants for apartments is vital. In the survey cited, most of the respondents liked the area in which they lived; 33 percent said they would rather live in another area of the city; and only 11 percent expressed a desire to move. The primary reasons given as to why people would like to live in another area were that they would prefer to be in a familiar neighborhood, be near better stores, and for proximity to relatives.

Other prime considerations in site selection include the proximity of public transportation and shopping facilities. Sites are chosen to be two blocks or less distant from a busline; easy access to a nearby grocery store and the principal shopping facility is essential. The locations of drugstores, parks and recreation facilities are secondary considerations.

COMMUNITY TRANSPORTATION

Since few sites can provide easy access to desired services, public transportation is essential to elderly persons in low-rent housing; very few residents own cars. Fifty-five percent of the persons surveyed said that they rode the bus every week or oftener; 13 percent rode the bus less often; and 32 percent never rode the bus—primarily because of physical disability. Many people said they could not step up high enough to enter the bus or that they could not tolerate standing to wait for it. For those able to use the bus, it is a very important service, enabling them to visit friends and engage in community activities.

What are the alternatives for people who cannot use public transportation? Taxicabs fill part of the need, and many people use them for "necessities" like going to the doctor. However, the cost is such that low-income elderly people cannot often afford a taxi. Another method is getting a ride with someone in the building who owns a car. Occasionally, transportation may be provided by relatives—usually children—who live

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nearby. The vast majority, however, are denied the possibility of such transportation assistance.

In the above cited surveys, 33 percent of the public housing elderly had no living children, and an additional 45 percent had no children residing in the same metropolitan area.

Another aspect of mobility is walking. The ability to get around on foot is important for social activities and community participation as well as for the daily necessities of life. Walking becomes a problem when the older person must leave the relative security of a building and face uneven sidewalks, curbs and other potentially difficult obstacles such as crossing streets.

Fifty-eight percent of the survey respondents did their shopping in the neighborhood stores. This short walk presents some problems, particularly in inclement weather when many aging people are reluctant to go outdoors. The problems of walking also deter people from attending local churches and other community activities.

Shopping is a problem. One advantage shared by many small grocery stores is that these frequently provide delivery services although they lack variety. Often the customer must go to the store to choose what items he wants, but the delivery service saves him from the problem of carrying his purchases home. Another alternative, a special free "shopping bus" service sponsored by several large stores, has proven to be popular with elderly residents. This indicates there are creative solutions.

MOBILITY IN THE BUILDING

The Minneapolis low-rent housing model described here is geared to provide features which maximize ease of mobility.

General Features

Thresholds in doorways have been eliminated for the convenience of wheelchair users and people who have difficulty walking. Doorways permit passage of a wheelchair and most buildings have ramps.

Buildings with more than one floor have elevators to eliminate stairclimbing, although a stairway is provided for those who wish to use it. The closing speed of elevator doors has been slowed for easy entry. The vertical speed of the elevators has not been changed as this does not seem to be a problem for older people. Additionally, all buildings are equipped with coin-operated laundry facilities which the majority of the residents use.

Apartment Mobility

The individual apartments provide several special features to promote and extend independent living for older people. Kitchens and bathrooms are the areas of a home where most accidents occur, and these are the rooms which receive special attention in housing for the elderly. Kitchens require fewer modifications to standard design practices than do bathrooms. The primary difference is that the kitchen cupboards have been lowered to put them in easy reaching distance. The kitchen has a gas stove and family-size refrigerator, since many older people have difficulty bending over to reach into the small apartment-type refrigerators. (It is noted that many designers prefer electric stoves.)

Showers rather than bathtubs are provided in all new apartments. The showers have a temperature control valve to prevent a sudden change of water temperature, and the shower head is mounted on a flexible hose. A metal stool is provided so that the bather may sit down while he showers. The shower stall is equipped with horizontal and vertical grab bars for convenience and safety.

Additional modifications of kitchens and bathrooms are provided for tenants who need extra help. These additions include extra grab bars in the bathrooms, grab bars near the toilet, hand railings around the apartment and other special devices for blind or deaf tenants. This special equipment is not provided in all apartments, for only a small percentage of aging people, who live independently are sufficiently disabled to require it.

The apartments have vinyl-asbestos tile flooring, which is the same material used in the halls. The newer buildings also have a master antenna system for television sets. Further, the apartment doors have locks which must be locked with a key from outside, thus preventing people from accidentally locking themselves out of their apartments.

SOCIAL ACTIVITIES

Visiting friends and relatives is one of the most frequent social activities of elderly people. Forty-five percent of the persons surveyed engaged in such visiting several times each week. Participation in more organized activities and formal organizations is more limited. However, when transportation is provided, more people attend organized activities. Forty percent of the respondents have gone to the Senior Citizen's Center, for which free transportation is provided once every week. More than half the respondents attend religious services every week. Several churches provide

transportation by bus or private car, and this service is helpful to people who would otherwise find it difficult to attend.

Recreational group work and information and referral services are provided by the Senior Citizen's Centers of Minneapolis through a contractual arrangement with the Minneapolis Housing and Redevelopment Authority. In addition, various social activities are sponsored within the buildings. Each building has a council, elected by the residents, which plans activities. There are also opportunities for informal socializing. Frequently, residents gather in the community room to play cards, talk or watch television. In the summertime, residents sit outdoors, enjoy the weather, or plan an impromptu lawn picnic.

Community facilities in the building include a lounge suitable for meetings and parties and kitchen facilities so that food can be served easily. The kitchen is also used by residents when they entertain a large group of people.

Besides consideration for the physical milieu, the social arrangement must be carefully considered so that the older person retains feelings of freedom of choice as to whether or not he wishes to participate in any given activity or, for that matter, any activity.

SUMMARY

Experience in providing low-rent housing for elderly people has indicated that adaptations in housing can promote a high degree of mobility and independence for older people. These modifications can make daily activities easier and safer, and contribute to an elderly individual's view of himself as a capable, self-sufficient person. It is indicated that the functional assessment of an individual or the extent of his ability to look after himself is intimately related to housing design. The rehabilitation team and the housing team, as they coordinate, become a part of the total effort to maximize mobility on the part of aging people.

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ACCIDENTS AND AGING PEOPLE

by

Manuel Rodstein, M.D.*

General intellectual deterioration together with the effect of chronic disease, malnutrition and fear, depression, rigidity, isolation, anger, and a clinging to habits and possessions of the past contribute to the accident toll in the aged.

In those over 65 years of age, accidents were as important a cause of death as pneumonia and diabetes. The time needed for healing and severity of complications, such as infections, heart failure, pneumonia, and disorientation, increased.

In 1962, 9.3 percent of the population 65 years of age and over sustained 72 percent of all fatal falls, 30 percent of all pedestrian fatalities and 29 percent of deaths due to burns and fires.[1,2] In addition to more than 25,000 annual accidental deaths in those 65 years of age and over, it is estimated that 3 million are injured. Of the latter, 200,000 are hospitalized and 800,000 are bed disabled, resulting in 100 million days of restricted activity.[3]

AGING AND CELLS

With aging, there is a gradual slowing down of the rate of division, growth and repair of cells, with function at a lower and less efficient level and a decrease in recuperative ability after injury or disease. The mass of the body without fat [with lean body mass] is maximal when the greatest height, nitrogen mass, cell mass, cell water and potassium are achieved. This occurs between the ages of 15 to 19 years, remains at a peak for only a short time, and is followed by a continuous and progressive decline, "senescence," which is at first slow and accelerates after age 40.[4]

Homeostasis

Homeostasis is the complex group of neuromuscular, cardiac and endocrine gland reactions, whereby the body maintains its basic physiological function, within normal limits, such as temperature, pulse rate, cardiac output, respiratory rate, blood pressure, oxygen supply to the tissues, blood volume and composition, and acts to maintain and restore such normal values under the stress of blood loss, fever, tachycardia, acute disease, and injuries. Under normal conditions these values are the same in old age as in youth, but as homeostasis becomes less efficient in the aged,[5] stress will cause increased degrees of departure from normal limits and a prolonged recovery time. A simple example is the response of the pulse rate to exercise with greater increase and delayed return to the initial level in the aged. Too, marked and prolonged falls in blood pressure on standing are not uncommon.[6] In severe cases where the blood pressure becomes very low or absent, fainting occurs.

Premonitory Accidents

Premonitory accidents are frequent causes of falls and injuries in the aged. A premonitory accident is one which occurs as the first manifestation of or shortly after the onset of an acute illness. The aged person continues to walk despite the illness because of a decreased appreciation of pain, a lessened febrile response to infection, and a tendency to ignore one new symptom among many already present. In a series of 147 consecutive accidents at the Jewish Home and Hospital for Aged, there were 37 premonitory accidents associated with acute attacks of heart failure, heart block, coronary insufficiency, hyper- and hypotension, cerebrovascular

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insufficiency, respiratory and gastrointestinal infections and bleeding.[7]

Central Nervous System

The central nervous system shows degenerative changes with aging. Several thousand brain cells die each day during the latter half of life. The brain decreases in weight, so that at age 75, it is 56 percent of its original weight.[8] Intellectual functions show early declines from their peaks. Number memory begins its decline at age 27 years, design memory at 32, inductive reasoning at 23, and tonal memory at 45 years of age.[9]

Reaction time is prolonged, learning capacity decreased, memory impaired and intellectual capacity diminished, especially where time limits for completion of testing are imposed. We may be consoled by the knowledge that among those with prior intellect, training and education, intellect is retained with little decrement before the mid-seventies. Mental tests scores are practically unchanged up to age 60 in the upper 5 percent.[5]

The prolongation of reaction time is an obvious cause of accidents in industry, among automobile drivers, pedestrians and in the home. The aged worker often perceives the impending accident, but cannot move fast enough to avoid it.[10]

Degenerative Changes

With advancing age, the chronic brain syndrome becomes frequent. Tests will make manifest mental deterioration with regard to memory, mental capacity and orientation as to time, place and persons. The physical deterioration which accompanies chronic brain syndrome, together with chronic illness and malnutrition, result in decreased altertness and self-care and a sense of detachment, which cause falls, burns, and pedestrian accidents. In the series of 147 accidents noted above, 48 occurred together with mental deterioration, chronic heart failure, chronic coronary insufficiency, Parkinson's disease, and definite impairment of gait.[7] Iskrant found that, although 45 percent of those who die from falls had no physical handicaps, 22 percent were unsteady or feeble, 7 percent had a cardiovascular abnormality, 6 percent poor eyesight or blindness, and 5 percent were lame.[11]

Gait

With aging, gait becomes uncertain and the feet tend to shuffle. Elderly females become bowlegged, waddle and step down with increased force. Hemiplegias, Parkinson's disease, lues and diabetic neuritis cause characteristic disturbances of gait. The feet are lifted a shorter distance off the ground. Extension cords, rug edges, minor irregularities in floors or sidewalks and thresholds become major accident hazards.

The Accumulator: A Social Degeneration

One type of aged person prone to accidents is the accumulator who saves everything and anything in a disorderly manner. He is subject to falls over his treasures, fires among them, or may die cornered and crushed by them. The accumulator is to be distinguished from the collector who has a plan, a purpose, and is proud to display his collection, be it match covers or theater programs.[12]

Balancing Mechanism

The balancing mechanism of the body is affected by degenerative changes in the cerebellum, loss of position sense and tactile sensation in the limbs, and decrease in muscle strength. Cerebellar damage is shown by the inability of many old people to stay erect with their eyes closed, even when standing on a wide base. As a result, older people lose the ability to pull back out of an incipient fall. A sudden loss of muscle tonus in the legs may account for the "drop attacks" described by Sheldon, where the aged person falls suddenly to the ground while retaining full consciousness.[13]

Extension of the cervical spine and the head results in dizziness, faintness and falls in many older people. This is attributable to compression of the arteriosclerotic vertebral arteries which are kinked and adherent to the bone in the cervical vertebral foramina narrowed by arthritis, with loss of blood supply to the brain. This accounts for falls among aged persons while putting in light bulbs, getting things off high shelves, adjusting drapes, standing in the window seat or painting off a ladder with head and arms up. Rotation of the head sidewise in the elderly may cause a deficient blood supply to the brain by compression of narrowed carotid arteries.[14] Thus, extension or rotation of the neck is a potential source of major automobile accidents when the aged driver suddenly looks in the side mirror or up at his rearview mirror. A head rest behind the driver's seat is indicated.

Vision

In 1666, Dr. John Smith in his book, *The Pourtract of Old Age*, noted, "The insensible approach of old age is nowhere so soon discovered as in the eye; and men are loath to think themselves declining in age so soon as the eyes give warning thereof." [15] He was referring to presbyopia due to loss of elasticity of the lens, which for most is the first overt sign of aging. As bifocals

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are needed, an accident hazard results in the resultant uncertainty as to where the feet are, particularly when descending stairs or a curb.

Many less obvious degenerative changes of the visual apparatus occur which increase the incidence of accidents in the elderly. There is an increased need for illumination, a decreased ability to distinguish varying intensities of light, a decreased speed of perception of light stimuli, a decreased tolerance of glare, a decrease in night vision and speed of adaptation to the dark, and a narrowing of the visual fields, especially of the lateral fields.

Between 16 and 90 years, recovery time from exposure to glare is doubled every 13 years.[16] The aged driver is easily blinded by the glare of onrushing headlights and does not easily distinguish dark objects on the road or cars on side roads. The aged pedestrian has difficulty making out green and red traffic signals, cannot read signs with small letters, and is prone to accidental injury from turning cars, usually traveling at less than 16 miles per hour at intersections and particularly on one-way streets.[17]

At home, the aged are prone to falls in poorly illuminated halls and stairways or on the hazardous night trip from bed to bath. Also common are falls due to missing the bottom step, because of the mistaken belief that the bottom of the stairway has already been reached.[13]

Hearing

With aging, there is progressive hearing loss, due to inner ear and otic nerve degeneration. Higher frequencies are lost, sound may become painful, and hearing may be good only against a noisy background. Accident prevention indoctrination is difficult with loss of perception of conversation; signal warnings—that is, the sound of a car or train—may be unheard; the world becomes dead as background noises, which keep us in contact with life, are lost. Depression, withdrawal and paranoia result with lessened self-care, apathy and accidents.

Pain and Other Sensory Perception

Decreased perception of heat, cold and pain together with slowed reaction time result in severe burns on contact with hot water bottles, hot wet dressings, heat pads or the hot tub. An especially disastrous result occurs when a heat pad is applied to a leg whose circulation is impaired by arteriosclerosis. This decreased perception of pain in the brain may cause an older person to have a "silent" myocardial infarction. Ambulation continues and a fall may result.[18]

Accidents are further caused by decreased acuity of the sense of smell which may result in undetected open gas jets.

Muscular Involvement

The loss of muscular strength, speed and coordination is not confined to skeletal muscle but involves the smooth muscle of the gastrointestinal tract as well.

The act of swallowing initiates a finely coordinated reaction by nerve and muscle, a sequential peristaltic wave of contraction of esophageal muscle, which transmits food from pharynx to stomach. In younger age groups, each swallow is almost invariably followed by such a successful, asymptomatic, peristaltic wave. In the aged, delayed and abnormal peristalsis occurs about half of the time.

Stationary localized contraction waves in the mid-esophagus are common which result in food being sent both up to the pharynx and down the stomach at the same time, or not to move at all. A grave danger of aspiration of food into the lung results, which will cause potentially fatal aspiration pneumonias. This is not uncommon in aged bedridden patients fed in the supine or semirecumbent position by overenthusiastic volunteers. (19)

Osteoporosis

The high morbidity and mortality from fractures in the aged is intimately related to osteoporosis. Bone is a living tissue which is the end product of continuous simultaneous processes of formation and destruction. Formation is stimulated by the stresses and strains of action and motion and by androgens and estrogens. This is in balance with the rate of bone resorption in the normal adult. With the decrease in estrogen formation after the menopause in the female, osteoporosis becomes a major problem. Less bone matrix is formed, the volume of bone decreases, the cortices are thinner and the trabeculae fewer. Total bone mass is decreased, although the chemical composition of bone is unchanged. The loss of bone is exacerbated by decreased activity. The process is less severe in males as androgens are still produced, although in reduced amounts.[20] As a result, total bone mass decreases about 10 percent per decade after the age of 45 years.[21]

The initial total bone mass is less and the rate of bone loss is greater in females. The process begins centrally in the vertebrae, pelvis and ribs and appears

later peripherally in the long bones and skull. The lumbar vertebrae show biconcave deformities as the discs protrude into the weakened bodies. The process is more evident anteriorly in the thoracic vertebrae with anterior wedging. As many as 25 percent of the aged develop fractures of the spine, often without any history of injury or with such minor stresses as sneezing or opening a window.[22]

In the aged, fractures of the neck of the femur may occur with only minor injury. These are five times as common at ages 70–79 as at 50–59 years. The incidence in females doubles every five years. The female to male ratio is 3.5 to 1. After age 45, the ratio of Colles Fractures of the wrist in females compared to males is 7 to 1.

Thus, fractures in the aged are more common and serious and are more closely related to the degree of weakening of the bone than to the severity of the accidental trauma. Our studies have shown that the accident causing a hip fracture in the aged is often the last of a series of falls which resulted in little or no injury. On the day of the fall and fracture, the bone was ready to break.

Accordingly, the reduction of morbidity and mortality due to fractures in the aged depends only to a degree on optimal medical, nursing rehabilitation and psychiatric care and an active program of accident prevention. The successful prevention of osteoporosis is of greater importance and remains unsolved. There is some benefit from long-term supplementation of the diet with calcium and Vitamin D, since long-term inadequate dietary intake has been found in many individuals.

The value of long-term estrogen therapy after the menopause has not been confirmed, although a recent study, using the measurement of the transmission of radiation through bone, has been encouraging. The danger of stimulating estrogen and androgen dependent cancer of breast, cervix and prostate with hormone therapy must be kept in mind.

Medication Effects

Since medications are not as efficiently detoxified in the liver and excreted by the kidney in the aged, an accident hazard is produced. The bromides and barbiturates reach higher levels and tend to cumulate with irregular, rapid heart rates more easily. Walking and driving become hazardous under such conditions. Left to their own devices, the aged are prone to errors in dosage, timing and omission of drugs or taking the wrong one.[23] The tranquilizers may cause dangerous falls in blood pressure on standing up.

PREVENTION OF ACCIDENTS

Falls

Accidental falls occur on staircases, due most frequently to missing the last step or group of steps in the mistaken belief that the bottom has been reached. This happens to most of us at one time or another, but in younger years we are able to regain our balance, even with difficulty, while the older person, once he starts to fall, continues to fall. This is the result of degenerative changes in the balancing mechanism in old age.

A contributing factor to this high incidence of falls on stairs is poor vision due to inadequate lighting, particularly at landings and on cellar steps, which are often steep and frequently lack handrails and illumination. Falls on stairs are most frequent at twilight. Dizziness on the stairs plays an important role in such falls and is most dangerous when climbing up the stairs, since falls backwards lead to more serious injuries. However, some old people get dizzy when looking down a stairway and suffer injuries falling down. The use of a new and unfamiliar staircase often leads to falls in the aged.

Handrails on staircases must be improved. A detached rail on both sides is needed and should be of a size which would permit a good, effective grasp reflex. Many handrails now in use are too broad or too close to the wall for a good sudden grasp reflex for support at the beginning of a possible fall. There should be an extra support for the handrail at the top and the bottom of the stairs; and the end of the rail should be specially shaped so one will know when one is there. The hand should not reach this area until the feet have left the staircase at the bottom, thus preventing the accident due to looking for a step that isn't there or missing a step completely.

Top and bottom steps should be painted, nonskid treads used, and risers painted an easily seen color. Stairwells which have doors should have windows, so that the aged will know that there are staircases behind them and that these are not doors to other rooms. Landings should be adequately illuminated.

Loss of balance on slippery surfaces is an important cause of accidental falls. The death rate from falls is highest in Scotland and the British Isles, and then declines steadily to approximately half the rate in Southern England. This is due to a greater amount of ice and snow in a more northern climate. Small mats, sliding rugs, slippery linoleum, something spilt on the floor, rubber shoes on wet pavements—all contribute to the

total of falls. Preventive measures are obvious: use of rubber-backed nonskid rugs, nonskid floor waxes, corrugated soles; discarding small sliding mats; tacking down of the ends of rugs; and removing thresholds.

Objects in Unexpected Places

An important source of falls in the aged is falling over objects in unexpected places, such as grandchildren and pet animals. Many old people are unable to stand erect when their eyes are closed even with their legs spread wide apart, and good illumination becomes essential. Baseboard lights and adequate lighting at the bedside table and from the bed to the bathroom at night are important preventive measures. Light switches in the rooms should be easily accessible at the door of the room, and flashlights should be handy for emergencies.

The solution lies in acts of prevention in addition to those mentioned such as removing low lying obstacles, installing wall-to-wall carpeting, removing extension cords, and eliminating too-low couches, chairs on casters, rickety tables and sharp cornered furniture.

Burns and Scalds

Burns and scalds are 3 times as frequent in the aged as in younger adults and call for a great many preventive measures. The frailty of all old people, their poor vision and inability to maintain posture contribute to the high morbidity and mortality from burns in this age group. Poor memory and inattention are also potentiating factors. Smoking in bed or in an easy chair, especially after a few drinks, may cause a stubborn fire and death.

The complex of dials and controls of a modern stove which resembles the controls of a computer may baffle and confuse an aged person—as such complex equipment often confuses many younger housewives. We should mark the dials on the stove distinctly so that the elderly person can see and feel the on and off positions.

We are spared in this country a danger of which the English so frequently speak. The aged person falls into or gets too close to an open fire. But we have special hazards all our own in our modern American homes. The peninsula cooking unit allowing an open approach has a potential for burns from three sides instead of from one. In the split-level house, the fire that starts in the kitchen may be in the bedroom in a few minutes. Grandmother, using the new oven in the wall without adjacent counter space, may turn around to put down a hot and heavy roast and trip over an obstacle. Burns in the bathtub are quite frequent. We need controls out of the tub or showers where the temperature can be preset, and a seat in the tub to restrict the area of body injury.

Burns due to clothing made of highly inflammable materials are common today. A noninflammable cotton is now available in England for use in pajamas or nightgowns for the aged.

Gas and Asphyxia

The aged suffer a loss of acuity of smell and are thus more exposed to danger from leaking gas lines or equipment, unignited taps or taps put out by boiled-over pots and pans. Suggestions have been made that gas be made with a more penetrating odor for the benefit of the aged. Spring-safety caps for gas jets are another suggestion.

Drugs and Disaster

Accidental overdoses of drugs are also a cause of fatality in the aged. Mistakes in dosage, sequence, timing, and omission are frequent. A periodic housecleaning of all medicine cabinets is indicated. Careful labeling of drugs, with large letters and with special notation of whether they are for internal or external use, is helpful. Good lighting in the area of the medicine cabinet, with a good magnifying glass available, would help cut down on the frequency of accidental overdosage of drugs in the aged.

ACCIDENTS IN INSTITUTIONS

Accidents to the aged in health institutions serving the aged are a major problem. One-tenth of accidental deaths among those 75 to 84 years of age and one-eighth among those 85 years and over occurred in such institutions. These included a not inconsiderable number due to fire and burns occasioned in burning institutions. Many of the aged cannot escape because of the infirmities of old age and disease, but numerous homes serving the aged have an excessively high incidence of fire hazards. Strict supervision and fire control measures are badly needed in many areas for this type of institution.

Those who are confused due to the effects of disease or drugs, severe cardiacs weakened by failure, terminal cases and those with muscular and skeletal defects are especially prone to falls out of bed. Relief for this problem must be sought through such devices as mandatory use of high-low beds for the aged, which are in the low position at all times, except when treatments are being given. In the low position, the feet of the aged person may reach the ground comfortably when he sits on the side of the bed and he does not have to hazard the

treacherous, slippery, small footstool so commonly in use with the old-fashioned high bed.

For the severely ill or disturbed aged, the ideal side rail has yet to be invented. Many in use only provide a higher point of departure for a fall for the disturbed aged person intent on going to the bathroom at night or going to a current or nonexistent past home. The old-fashioned high rail is more effective than the modern low, split type.

Other desirable devices are the grabrail for the toilet seat, the grabrail for the bathtub, the bathtub approachable from three sides to give aid to the aged in bathing, the nonskid mat in the tub or emery coated nonskid stripes in the tub, and the careful regulation of the temperature of the water. Toilet seats should be high enough so that the elderly person can get on and off without dangerous sit-downs. The doors of bathrooms should preferably be of the type so that wheelchair patients may have easy and comfortable access to the interior of the bathroom without leaving the chair at the doorway.

The ideal wheelchair has yet to be invented. Many are grave accident hazards. One can get tripped up by the foot rests, by inadequate hand grasps on the side rails, by poor, weak structure, and by rolling away due to poor or inadequate braking. And sharp wheelchair edges can impair the circulation to the legs.

In the care of the aged, staff training is imperative. How to move patients in bed and on and off stretchers with care is an art.

AUTOMOBILES AND THE AGED

Special problems are presented by the aged with regard to the operation of motor vehicles and as pedestrians. Poor night vision, poor tolerance of glare, a diminished field of vision, and lessened visual acuity coupled with slower reflexes make the aged person both a more accident-prone driver and a more accident-prone pedestrian.

The Elderly Driver

Arthritis of his spine and his neck makes it harder for the elderly driver to turn his head sidewise when engaged in backing up. Looking up at his rearview mirror or sideways may be a hazard by constricting the circulation of blood to his brain. The unpredictable effects of medication in the aged also make him a greater automotive accident hazard. Confusion, drowsiness, impaired reflexes, even excitement may result. Bursitis of the shoulder hinders his turning motions even with power steering, and ordinary brakes demand power. Power brakes need fine coordination, and an aged person with poor coordination may be a definite menace both to himself and whoever is driving behind him.

What modalities of accident prevention are available for the aged driver? Visual and hearing defects should be corrected. Medication should be given in relationship to the time of driving so as to avoid maximum effects at those times.

Training should be given in the meaning of new traffic signs and laws. Explanations should be made by the physician to the driver as to the limitations imposed by disease on driving ability. The frequency of driving should be regulated; night driving and driving in bad weather should be curtailed, as should the use of difficult and high speed routes. The decision to stop driving involves the driver, family and physician and is complex to resolve in a culture dependent upon the automobile.

The Elderly Pedestrian

A greater percentage of those over 65 were killed or injured crossing at intersections (57 percent) than among any younger age group, and a smaller percentage of those over 65 than among any younger age group were killed or injured while pursuing such inadvisable activities as crossing between intersections (20.9 percent), crossing behind parked cars (3.8 percent), or walking in the roadway (2 percent).

Suggestions have been made that ramps be built at crossings rather than high curbs on which the elderly pedestrian may trip or fall; that some easily distinguished clothing articles should be worn at night; and that longer and more intensive traffic lights should be used. The time needed by many aged people to cross city streets with a single light is inadequate for their abilities. The question of when unaccompanied ambulation on the streets for the aged person must end is a difficult one.

INDUSTRIAL ACCIDENTS

Industrial accidents among the aged are lower in incidence than in younger workers. It may be that their work is less dangerous or that they are more careful, since they are worried about the effects of an accident in terms of prolonged disability, loss of pay or loss of job. Accidents in the aged involved longer sick leave due to slower recovery, and often precipitate premature retirement.

Many industrial accidents in aging persons develop from an insistence that they can climb, lift and pull

as well as ever. If their work is carried out under pressure, they will have an undue proportion of accidents. However, if they work at a speed adjusted to their capabilities, their accident rate diminishes. Those older workers who are more accident prone than others of the same age have been found to have the same perception of the sudden hazards, but to have a deficient speed of motor reaction in the avoidance of the accident itself.

Older workers develop great care and accuracy and have less accidents due to such causes as being caught in a machine or inflicted by their own tools, but they have more accidents due to falls from height or machine, slipping or tripping on the ground, or being hit by falling or moving objects. Elderly women fall on the level on the job; elderly men get hurt handling goods and falling.

SUMMARY

There is a continuous alteration of the structure and functional capacity of the body with aging which results in a decreased ability to deal with stress, and an increased susceptibility to, and slowed recovery from, accidental injury. It is also noted that the senescence varies widely between individuals in the rate and degree of change and loss of functional capacity.

The occurrence, type, and degree of injury sustained in accidents in the aged is closely related to the specific physiologic and organic deficits and acute and chronic illnesses present at the time; and the effectiveness of methods of accident prevention in the aged depends upon an understanding of the aged and the aging process.

Emotional strain, boredom, lonesomeness, preoccupation, anxiety, aggression, authority, frustration, fear and excitement make aging people more vulnerable to accidents.

A survey of several thousand elderly individuals living in the St. Petersburg area of Florida revealed that over 90 percent had no limitation of mobility or activity, and less than 10 percent respectively had difficulty in reading or deafness.[17] Further, over 80 percent of more than 1,000 aged residents of an institution for the aged and of an office practice of similar size had good useful vision.[24 25] In Deuteronomy we may find consolation in the statement that "Moses was 120 years old when he died and his eye was not dim."

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REHABILITATION OF HOSPITALIZED AGED PATIENTS

by
Sidney Katz, M.D.*

Though the standards and practices of care for hospitalized aged patients are similar in many ways to the standards and practices for care of all hospitalized patients, special problems of the aged lead to different emphasis in the process of care.

Special Problems of Aged Patients

Aged patients as a group have a greater probability of long-term or chronic illness. They have a greater risk of having more than one illness, and their illnesses are more likely to be associated with or lead to disabilities. Neuromuscular difficulties may lead to disabilities in daily functions as bathing, dressing, walking and stairclimbing. Weakness and decreased physical and mental tolerance to stress are more apt to cause geographic confinement and narrowed social interaction. In the presence of the increased dependence on others which is fostered by disability, there is often and paradoxically a decrease in the number of able friends and of family.

Along with isolation, aging people are more subject to problems of desolation at such times of personal crises as death of spouse, geographic relocation and change in social role. Socioeconomic productivity decreases and financial resources may be depleted. Educational resources of the ill aged are likely to become obsolete and mental function slows. To those who care for him, as well as to himself, the increased prospect of death may become a problem.

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Functions of Hospitals

The hospital admits aging patients at a time of increased need and hospital resources are faced with the responsibilities of increased risk. The Commission on Chronic Illness has identified certain areas of hospital function which are especially important to good institutional care for long-term and aged patients. The areas of concern include: "(a) admission and discharge policies; (b) individualized services; (c) rehabilitation; (d) personnel; (e) administrative practices; (f) health services; (g) adequate financing; (h) design and construction; (i) standards of care." [1] The needs of the aged high-risk group require the addition of new community based resources and facilities—especially to hospitals—and extension of existing resources, again, usually to hospitals.

REHABILITATION IN THE HOSPITAL

Rehabilitation is selectively emphasized here as a constructive concept which underlies the appropriate use of hospital facilities when one considers the hospital's role in relation to the risks of the aged patient. Rehabilitation is defined by the National Council on Rehabilitation as ". . . restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." [2] Rehabilitation, as a necessary element of adequate care, begins with diagnosis and comprehensive evaluation of the patient. It is an interdisciplinary concern of a team of generalists and specialists which includes multiple professional disciplines assisted, as appropriate, by trained aides.

In the new and unfamiliar hospital setting, the aged patient often functions at less than his optimal level. The time which is needed by him to adjust and for the team to become acquainted with his level of functioning is considerable; yet this time must be spent, since the team

requires baseline measurements in order to evaluate needs, to set goals and to assess subsequent rate of progress and effectiveness of services.

Rehabilitation Goals

Meaningful and realistic rehabilitation goals vary from patient to patient. In setting goals, it is emphasized that rehabilitation is a patient-centered tool of the team. It is not staff-centered as an organizational device into which patients fit. For some, the goal may be to rehabilitate toward a partial or full return to the community. For others, the goal may be toward a degree of nursing, medical or social dependence which is less than the degree of dependence present at the beginning of the rehabilitation process.

Restorative Activities

As the patient's need changes, regularly scheduled reobservation and quantitative reevaluation lead to changes in goals. Program is reinforced by practice and tolerance is increased. Training and therapy are adjusted to compensate for, or to overcome, disability. In the case of irreversible and continuing need for assistance, recognition of this fact is taken into account in setting long-term goals. Also evident is the need for objective criteria to measure function and for regularly recorded, quantitative assessments of function.

In a broad sense, restorative activities include specialist-supervised therapy which continues into nonspecialist-supervised environment. Thus, for example, active physical therapy exercises and activities continue the physical therapy goals at times when a patient is not being supervised by a physical therapist.

Patient education becomes an integral part of restorative activities. A nurse may, for example, stand patiently by while a patient fumbles in putting on a sock or while the patient puts a shoe on the wrong foot. The nurse may attempt to increase the patient's awareness of his limitations in function. She may demonstrate, reassure or encourage the patient and thereby promote restorative reeducation.

Channels and Communications

Though not all members of the rehabilitation team may be involved at all times with any given patient, the need for an integrated program with effective communication and coordination is evident. Essential to the program are open channels to resources which are not available in the hospital environment, as, for example, to financial resources, to nursing home facilities, to ambulatory care programs, to home care programs and to transportation aids. The search for such resources and the liaison necessary to maintain open and effective channels is a time-consuming responsibility. Once accepted as a responsibility, input of information about resources and channels should be systematically recorded as an ongoing process and as a readily available registry for the use of staff and for the education of new staff. Continuing education and feedback of information to staff permits personnel to function as effectively as possible.

FOLLOWTHROUGH AFTER HOSPITALIZATION

The need for followthrough after the patient leaves the hospital is often a responsibility which the hospital does not take. When community resources are not available to accept followthrough responsibility, a certain number of patients who should get back to the community never do, while others get back to the community without being able to remain there. Whether the hospital can or cannot accept followthrough responsibility, long-term information about the course of events in those patients discharged from the hospital is important to those involved in the rehabilitation process, since it enables them to develop knowledge about the effectiveness of their services. Systematic recording of followup information about patients will lead to innovational decisions within the hospital which are directed toward greater effectiveness.

Several examples of followup effort demonstrate the type of information which can be derived and its value. The Benjamin Rose Hospital of University Hospitals of Cleveland has accumulated followup data for more than 10 years about a group of consecutively-admitted patients with fracture of the hip and for more than 7 years about a group of consecutively-admitted patients with cerebral infarction.[3 4]

Long-term observation of those with fracture of the hip showed that most full and partial recoveries occurred within 1 year after fracture, with little chance of recovery after 2 years. Recovery in activities of daily living tended to precede recovery in walking. When recovery occurred, it was generally sustained for 2 years or longer. Predictors of a poor outcome were advanced age, prefracture disability, and associated major chronic diseases. The estimated average remaining lifespan after fracture was 6½ years in contrast to a value of 9 years for a comparable unselected population in the east-north-central United States.

Followup of the group with cerebral infarction indicated that the majority of recoveries occurred within

6 months after stroke, and there was little likelihood of recovery after 2 years. When recovery occurred, it was generally sustained for a year or longer. At the end of 2 years, 6 of 10 survivors walked without personal assistance and received minimal or no assistance with activities of daily living. Four of the 6 were at prestroke functional levels. Advanced age, the absence of early neuromuscular improvement, the presence of more than one stroke and the presence of associated major chronic diseases were associated with a poor outcome. The risk of death after stroke was greater than would be expected for the population in general, and the accelerated rate of death subsided by 24 to 30 months after stroke. The predictive information gained from these followup studies is important in decision-making during rehabilitation.

The desire for more information and better follow-through of rehabilitation led to establishing a followup clinic. Of interest was the demonstration that older and more disabled patients were generally unable to come to the clinic. Such studies led those in the hospital to desire more responsible efforts toward continuing the rehabilitation process after patients were discharged from the hospital.

This, in turn, led to a public health nursing program experiment in the homes of 150 disabled aged patients discharged from the chronic disease hospital, with a control group of 150 randomly selected similar patients from whom this treatment program was withheld.[5] Early results indicate a trend toward fewer patients deteriorating in activities of daily living and in walking among those receiving public health nursing assistance, than among those not receiving such assistance.

FUNCTIONAL ASSESSMENT

On the basis of experiences with longitudinal studies, a schedule of measures was developed to observe the course of illness and to help make decisions about effectiveness of therapy. Included were baseline measures which characterize the aged chronically ill and their pretreatment functional levels as follows:

Age
Sex and race
Primary diagnosis
Concomitant illness [3]
Activities of daily living (Index of ADL) [6]
Walking [3]
Range of motion and strength [4]
House confinement
Marital status
Occupation
Education
Social class (adapted Hollingshead) [7]
Economic resources and productivity [8]
Household composition
Identity of people who assist
Recent personal loss or change in role
Social interaction frequency (adapted Townsend) [9]
Intellectual function (Raven test) [10]
Memory and mental control (adapted Wechsler) [11]
Scale of psychosocial adjustment (Highland View) [12]

Reevaluation in order to study changes and thereby to make decisions about the results of therapy are expressed in the following terms:

Death
Activities of daily living (Index of ADL) [6]
Walking [3]
Range of motion and strength [4]
House confinement
Duration of noninstitutional living (independence)
Hospitalization
Admission to nursing home
Socioeconomic functioning (Index of ISF) [8]
Social interaction frequency (adapted Townsend) [9]
Intellectual function (Raven test) [10]
Memory and mental control (adapted Wechsler) [11]
Scale of psychosocial adjustment (Highland View) [12]

This schedule is not necessarily a panacea. It can be shortened to suit time requirements of a variety of evaluation goals. Other measures can be substituted or added when necessary. Means of quantitative multidisciplinary assessment are, therefore, available and feasible. The emphasis on function in the schedule is acceptable since value judgments about human behavior are often made in terms of the adequacy or inadequacy of function. Level of function is also important since it can be measured objectively and is an index of the existence and course of illness at a time when knowledge about etiology and pathogenesis is not advanced enough to permit precise measurement in these latter terms. Function thus becomes a useful longitudinal tool, and its measurement is an essential element in a sound rehabilitation program.

SUMMARY

The processes of hospital rehabilitation, post-hospital rehabilitation and long-term followup were selected for special emphasis, and illustrations were included on the value of followup information which influences hospital and post-hospital rehabilitation. A multidisciplinary evaluation schedule of applied importance to these areas is suggested and intimately relates to the extent to which aging people may regain maximum mobility to allow them to live as independently as possible.

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SATISFYING USE OF TIME

by
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Time is at the core of all discussions on leisure. Leisure, in turn, is equated with the doing of things one wishes to do. And yet, time and leisure become as one for retired people unlike those, usually younger, who share the use of time with work.

LEISURE DEFINED

Lundberg's classic definition stated that leisure ". . . is the time we are free from the more obvious and formal duties which a paid job or other obligatory occupation imposes upon us. In accepting this definition, we are not overlooking the interdependence of work and leisure. Such terms are mere pragmatic ways of designing aspects rather than separate parts of life. It remains a fact, however, that nearly all people can and do classify nearly all their activities according to these categories in such a way that is deeply meaningful to themselves . . . ." [1]

As we look at leisure in its ideal form, it becomes increasingly recognizable that a construct of leisure which puts it only in a dichotomous relationship to work is an oversimplification of the reality. Everything we do has some blending and some mutual values. Even so, if we accept a cash payment for services performed as against nonpayment for voluntary services performed, we at least have a gross definition. This type of definition may have a more meaningful interpretation relative to the older person who is fully or partially retired than it has for the younger, working adult. In this context, then, there may be some validity to the view that for the retired older adult, all time is leisure time—if he is no longer on a remunerative job—or at least that portion of his time which is on a contributory basis.

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EVOLVEMENT OF ATTITUDES TOWARD LEISURE

With large-scale industrialization, leisure has now become available to almost everyone in the United States. With ours being a work-oriented culture, leisure is considered not only as free time, contrasted with work, but also as time which has been earned. For the retired person, all time may then be considered as being paid for by the many previous years of work.

Leisure as Sinful

Realistically, however, the older person of today may be faced with conflicts as to the use of time because of the historical conception of nonwork activity. Such a conception stated that leisure is wasteful and is to be minimized or it is sinful and to be avoided. Puritan theology, which permeated the several hundred years of our existence, placed emphasis on work as being necessary for divine salvation.

Leisure as a Restorative for Work

The major immigration periods of the nineteenth and early twentieth centuries reinforced the view that work was honorable and led to the currently acknowledged norm of leisure as being acceptable—but only as a restorative for work. Traditional work norms were reinforced by the class composition of immigrant groups. As Williams noted, ". . . the population of this country was mainly recruited from the working classes of Britain and Europe; except in a few areas of the South and New England, there was no aristocratic class to give

prestige to leisure and to stigmatize manual labor and trade . . . ." [2]

In contrast to a still earlier period when work was equated with survival and idleness was despicable, industrialization—while still placing work on the same level—altered the motivations for work. In addition to sustenance needs, work became increasingly related to emotional and psychological needs. One's conception of self became more centered in the job. Leisure becomes desirable if it is used as a restorative for more and better work.[3]

Leisure is then considered to be a release from job obligations, but chiefly to those activities which refresh oneself again for work. As Riesman has commented, ". . . an attenuated puritanism survives in his exploitation of leisure. He may say, when he takes a vacation or stretches a weekend, 'I owe it to myself'—but the self in question is viewed like a car or house whose upkeep must be carefully maintained for resale purposes . . . ." [4]

Leisure and Status

The traditional conception of leisure is equated with utilitarianism. Therefore, we find that the norms of business life have become enmeshed with leisure. The concept that it is desirable to spend leisure profitably emphasizes this interrelationship. The ". . . very symbols of group speech swing around economic values . . . ." [5] While all leisure cannot be completely interpreted in this manner, it is known that membership in certain clubs and organizations is frequently used to enhance occupational status. The utility of these organizations, therefore, must be reassessed for retired people who are no longer seeking enhanced occupational prestige, but who are rather looking to the continuation of an acceptable form of status for self.

"Ideal Construct" of Leisure

Max Kaplan has given us six essential elements in his "ideal construct" of leisure.[6] They include:

1. Antithesis to work as economic function, or being outside the economic system in the usual way one relates to that system.
2. Pleasant expectation and recollection, or pleasure one gets from both expecting a satisfying experience and then recalling the experience.
3. Minimum of social role obligations, or greater or lesser roles of a voluntary nature as compared with mandatory roles due to work necessities.
4. Psychological perception of freedom, or how the individual who participates in leisure believes how free he is to do what he wishes.
5. Close relation to cultural values, or how leisure is intimately tied in with all of our social institutions.
6. Equal significance for all areas of life, or the view that since leisure includes interests covering the whole range of human life, the degree of seriousness of the activity is irrelevant.

EMERGENT ATTITUDES TOWARD TIME

The emergent norm suggests that leisure is moving away from being solely a subordinate to work. Individuals who participate in leisure activities perceive the use of their free time in countless ways. The broader the contexts in which they perceive their freedom to act, the more difficult it may become to conceive a definition of leisure to fit all people. Even so, we have begun to move into an era where leisure is looked upon as an important part of life. *Leisure, then, is to be looked upon as a worthwhile goal in itself, as contrasted with being a means to the goal of work.*

Evolving Norm of Leisure

Obviously, we have not made a complete transition, so that we have an intermingling of the contemporary and emerging norms of our society. As Kleemeier stated, ". . . The problem will be satisfactorily solved only with a fundamental reorientation of our value system. This does not mean we must denigrate the value of work, but that we must elevate the values of other uses of time . . . ." [7] As we look upon the retired person, then, we are faced with elevating his roles and the way he uses his time so that changed roles and changed activity have a meaningful acceptance in the value structure of the American society.

The meaningful use of time is often stated in such a way as to suggest a retired individual must find interests and create relationships by himself, standing apart from his life setting. This appears to be an overstatement of the freedom of choice for, as Thompson and Streib point out, ". . . the overwhelming majority of people, young and old, live their lives in and through social relationships which pattern their use of time and determine, facilitate or limit those courses of action which may be regarded as meaningful. Family relationships are among the most important patterns of the culture as to leisure, and they help define roles and functions of its members. Family activities contribute

in themselves a meaningful activity for the older person . . . ."[8]

Effect of Retirement

Retirement suddenly presents a great amount of leisure. That leisure which was once merely a period of refreshment now becomes an end in itself. The recognition, status, prestige, self-expression and friendship once afforded by work is now being derived from leisure.

The average American, however, lives in a culture that still manifests a distrust and suspicion of leisure; he is imbued with a puritanical faith that life without work is meaningless. But the traditional values of the past can only cause dislocation if they are not revised to be in keeping with evolving conceptions.

Adjustment to retirement can be aided in part by becoming psychologically prepared for it. A further part, of course, involves the attitude and individual perception of what constitutes a worthwhile role. How leisure activity or recreation is defined by the older person is important. Some older people insist that they are so active as volunteers or as members of an organization that they have no time for leisure.

For others, leisure time pursuits represent the uselessness to which society has relegated them. For example, retirement from work is difficult to accept as a normal phase of life by some farmers. This is readily understandable, since retirement comes into conflict with their social values of usefulness and productivity.

The older person of today clings to a tradition of culture in which work is all-important and in which success and achievement have been correlated with work. The older person of tomorrow may have been oriented at an earlier point in life to the acceptance of leisure as an end itself. Hence, programs for people must give them a chance to realize acceptable roles through leisure and through recreational activities. New meanings for leisure must be found by which persons can use their free time to contribute to their community and be held in respect and dignity, even though their contributions are not made through work.

Although organization is the rule in almost every phase of modern life, retirement is often entered upon without adequate planning or thought. The relinquishment of work and the beginning of retirement cause significant changes in daily routine and a possible disruption of social relationships. An appropriate understanding of leisure may preserve dignity and respect for the older person, even when his social status has changed.

TIME AND RECREATION

It may be useful at this point to distinguish between leisure and recreation. Recreation means to restore or refresh (note the Latin word *recreare*) and refers to certain activities like sports, athletics or games, all pursued during leisure and designed to allow the participants to return to work refreshed. Leisure time, however, is spendable in numerous ways, of which recreational activity becomes only one of these ways.

Recreation Objectives

Recreation operates in a culture which puts a stamp of approval on doing something for more than "just for fun." In this context, golf has therapeutic overtones; bridge sharpens the wits and provides social contacts; dancing is fine for mental well-being and keeps one limber; rolling bandages is a service to others; singing is an excellent program device for a group or mass meeting; and the sale of a hobby-craft item by an older person is acceptable, for it shows society that an older person is still a somebody.[9]

Objectives of recreation include:

1. Companionship and fun
2. A sense of belonging to the community
3. A feeling of contentment
4. Opportunity to receive recognition
5. Outlet to develop new interests and skills and retain or renew old ones
6. Occasion for both continuous learning experience and arousing interest in order to stimulate learning
7. Assistance to adjust in a changing environment

Recreation is further aimed at dispelling the attitude of "what's the use, since I'm now too old;" at offsetting the deadening effects of loneliness and aloneness; at parrying the consequences of reduced income; and at replacing declining health with increased efficient use of remaining capacities. These objectives are also to be found among the newer goals of community planning.

Several new types of recreational programs have appeared within the past two decades. We have recognized, to a large extent, the necessity of recreation for older people, and we have evolved several forms for its attainment. More often than not, our attempts to provide recreation have been geared to meet one particular situation at one particular time. One of the questions to be answered is: When do we take recreational programs to the older people and when do we have them come to such programs? In either case, recreation

must be geared to the daily habits of the older adult as modified by his place of residence or his mode of living.

The consequences of minimal group associations which many older people experience are now being met in some instances by substitute associations replacing or supplementing those formerly experienced. The interplay of environment and personality assumes particular importance when we consider the individual needs of older adults, their special needs, and their general needs as citizens of the community. Not all older people want the same activity or group associations, although nearly all of them are interested in some activity and some group contact.[10]

SPECIAL EFFORTS TO PROVIDE MEANINGFUL USE OF TIME

Contemporary characteristics of older people give indications of their changed position in the emerging society as compared to that in the society of past and present. Greater free time in our society is coming at a point of longer life, better health, reduced economic pressure and an earlier retirement age for an increasing number of people. With more free time, older people are presumably more able to participate in voluntary associations than younger people, although free time, or time away from one's work, is increasing for the younger ages also.

Extended Family Breakdown

The long time societal trend has been toward the breakdown of the extended family. Of the traditional institutions which provide social contacts for the individual, the nuclear family alone has remained as strong as it was in the preindustrial period. And while children still feel responsible for their parents, it is a different kind of responsibility than in earlier decades. The nuclear family excludes the aged. By definition it separates more than two generations within the same household and includes only one adult generation in the household.

This loss of regularized family social contacts for most older Americans suggests the vitalness of voluntary associations in meeting the psychological needs of the elderly, whereby group associations become important in the maintenance of mental well-being.[11] The voluntary association seems to be well-structured to satisfy those who wish social contact in modern society. Insofar as this emergent society has become increasingly anomic, the voluntary association has become an acceptable means for warding off loneliness.

Modern Recreational Programs

Recent national movements of formalizing efforts to provide meaningful uses of time for elderly include:

1. The golden age club
2. The senior citizen center
3. Institutional activity programs
4. Recruitment of retired people to perform socially acceptable tasks

Both the golden age club and the senior citizen center have the same general purposes. These include goals such as the following:

1. To provide a purpose for retirement living
2. To do and learn to do what one wishes to do
3. To make new friends and retain old friendships
4. To recreate old hobbies
5. To learn new interests
6. To mix with people who are interested in you
7. To serve other people, if one so desires [12] [13]

The overall goal is to provide a purpose for living in the latter years, regardless of which purpose an individual participant may select.

The golden age club—meeting once a week to once a month—and the senior citizen center—meeting 2 times a week to 7 days a week—have been relatively recent innovations. The modern golden age movement began in the late 1940's although clubs for older people were known to exist as far back as 1870 in Boston.[14]

The first senior center was created in 1944 by the Welfare Department of New York City. The basic purpose of the senior center is ". . . to provide older people with socially enriching experiences which would help preserve their dignity as human beings and enhance their feelings of self-worth . . . ." [15] We have no accurate measurement of numbers of golden age clubs, but there is no question they number at least in the several thousands. In 1970, more than 1,200 senior centers in the Nation were identified in a directory prepared by the Administration on Aging and the National Council on Aging—a sharp rise from the 340 identified in a similar directory in 1966.

Institutional Programs

Institutional programs vary almost as widely as the criteria for acceptance and definitions for these institutions. Leisure time programing has become increasingly accepted as an aid in retention of the personality of the residents and patients.[16] With program being planned around the interests of the older people rather than the staff, although particular skills of staff are utilized, the probability of meeting the social and psy-

chological needs of the older people themselves is enhanced.

Kleemeier, for example, pointed out that in special settings, such as homes for the aged, nursing homes and hospitals, responsibility of the life pattern of the individual is, in varying measure, assumed by the program of the institution. The activity program is sensitized to the characteristics of the settings and the residents. He noted that there is a greater potential for the presentation of an array of activities than most of these special settings are currently providing.[17]

SUMMARY

The recruitment of older people to undertake socially acceptable tasks has, to a certain extent, become related to employment.[18] The foster grandparent program was the most widely publicized effort in this area. However, the free time of the vast majority of retired people is precious to them and their apparent wishes are to be involved in socially acceptable roles, but essentially on *their* terms which would not include the regimentation necessary in work roles.

Although leisure originally was considered sinful, it is more and more being accepted as a valuable goal in itself. As societal values change, leisure habits change. Regardless of whatever the leisure habits may be at any point in time, what may be most paramount for society to consider is how to continue to broaden social role opportunities by the elderly. And while we broaden and give acceptance to newer social roles, an ever increasing range of activity choices will become available.

The greater the number of choices, the greater the potential of reaching out to all older people so each, in turn, may find his own way toward a satisfying use of his time as he sees it, feels it and lives it.

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CONFUSED AND DISORIENTED ELDERLY

by
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Alongside the organically caused disabling and chronic physical illnesses suffered by many aging people, we find the disability variously described by physicians as "senility," "senile psychosis," or "cerebral arteriosclerosis." The symptoms are often suggestive of a functional rather than an organic disorder, resembling those of mental illness. Like a psychosis, the causations of these symptoms may be physical, psychological, or perhaps a combination of both. The specific etiology is often difficult, if not impossible, to ascertain.

SYMPTOMS OF DISORIENTATION

The symptoms displayed by those suffering from this disability are varied and troublesome both to the aging person and to those around him. Many of these elderly are agitated and, in their activities, agitate others. They appear to have excessive energy and are seen to be pacing back and forth or taking long walks. They often speak in very rapid fashion, their words tumbling out in a steady, unintelligible stream. They wander away in compulsive fashion, as if seeking some more familiar, happier place.

These aged are often disoriented as to time and place. Their contact with present day reality fluctuates from day to day. At times the impression is given of normal, rational adequacy. Then the disorientation reappears.

In these persons, a loosening of both physical and emotional controls has been observed. Sometimes the aged person becomes incontinent, and may be surprised by this himself. Gross irritability and frequent expressions of rage and hostility are common. Temper tantrums are frequently the order of the day, triggered off by relatively small incidents, so that the reaction appears to be disproportionate to the precipitating event. The hostility may be expressed verbally or in actual physical attacks, with cane, fists, or whatever is handy. Yelling and screaming are also observed. Loosening of other controls is noticeable in certain aged persons who continually disrobe or whose ideas and speech are highly colored with gross sexual connotations or obscenities.

Delusional, paranoid ideas occur in some instances. The concept of people stealing money from them or of being poisoned are illustrative of usual examples. Often these aged express extreme religious fervor, claiming to have direct contact with the Lord.

TREATMENT FOR THE DISORIENTATION

In general, the overall medical-social treatment of such situations has been nonproductive of results. Many so-called "senile" patients occupy beds in public or private psychiatric facilities. Tranquilizing drugs, including barbiturates, are relied on heavily for control of these patients, with mixed results.

Observations of the effect of tranquilizers with elderly patients give rise to many questions as to benefits, both short- and long-range. In certain aged persons, these drugs appear to produce a reverse effect, for they seem to stimulate rather than calm the patient. Certain patients appear to improve when the dosage is reduced or discontinued. For the latter grouping, confusion and disorientation seem lessened, vision increases, gait is more steady, and anxiety is reduced. Yet for others, the same improvement is noticed when drug dosage is not reduced.

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Nutrition appears to play a part also in certain elderly persons whose nutritional intake has been marginal or deficient over a period of time. Observations have revealed a marked improvement in cerebral and behavioral function when adequate nutrition is instituted. At the same time medication such as nicotinic acid to increase the blood flow to the brain has had considerable success in certain aged patients, with resultant improvement of physical and mental functioning.

Other successful approaches include use of a professional service team—physical, occupational, speech and recreational therapy, social group work and social case work, nutrition, nursing—all under a physician's order, so as to provide maximum stimulation to the confused patient and maintain or improve his contact with reality and prevent further regression.

MIXING WELL AND CONFUSED PATIENTS

Specialized training and orientation are necessary for those on the staff who deal with the confused patients. Specialized building design plays an important part in physical control of the wanderers and in providing facilities to meet these special needs.

The presence of confused and disoriented aged in the midst of those with unimpaired mental faculties produces anxiety and fears among those who are well. Group facilities for the aged report numerous difficulties in the handling of the confused aged as part of the total group and have of necessity developed methods of segregating the patients. Sometimes one wing or one floor is reserved for them, sometimes separate buildings are used.

LEGAL PROTECTION FOR THE CONFUSED

Legal questions arise in connection with the protection of those whose judgment is impaired, particularly in the milder or beginning confused patient whose disorientation may be slight or fluctuating. Family members are often concerned lest the older person's failing judgment leads to financial exploitation; yet at the same time they are reluctant to institute guardianship proceedings or request a power of attorney from the aged person, since the latter may still be able to express good judgment in certain areas of functioning.

Institutions which care for the aged are reluctant to play the role of legal guardian, even though difficulties often arise in obtaining guardianship of the person where there are no assets or estate. At present, society has developed no appropriate alternate for protection of aged persons in these latter situations.

CONCLUSION

Confusion and disorientation are found among a number of aging persons. While minor compared to the total of the elderly, these conditions are significant because of difficulty of etiology and problems involved in treatment. Certain of the symptoms are well known. The effect of disoriented older people on older mentally alert people is usually adverse, and this poses a serious problem in facilities which care for large numbers of the aged. While legal protection is available for the elderly with assets, there are difficulties in obtaining legal protection for the disturbed person who has no assets and is residing in a community institution.

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PROTECTIVE SERVICES FOR THE AGED

by

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In considering the complexity of protective services for the aging, it is essential that we consider such factors as: all relevant knowledge bearing on the specific nature of the problem; the precise dimensions of the need; the range of services required; the financial and structural resources available; and the organizational arrangements required to assure provision of and access to an interrelated and integrated system of services and facilities whenever required.

PROTECTIVE SERVICES DEFINED

Protective services may be defined as, "Those activities undertaken by an individual or agency on behalf of certain recognizable incapable or incompetent older people, and which have as their goal the placement and continued care of these older people under some form of legal supervision . . . for their own or others' protection." [1]

This definition means *taking responsibility* for certain older people; asserts as a goal their placement and continued care; and invokes *legal sanction*, or authority, to do this.

The distinction is made between a protective service, as such, and the more traditional kinds of health and social services. The *potential for legal authority* is posited as the distinguishing element between these services. This is important not only because it is generally unfamiliar to the large body of professional practitioners engaged in rendering traditional community services to persons in need, but also because it states a function and responsibility which most social agencies prefer not to assume.

CLIENT PROFILE

Practitioners with the aging are faced with the situation of the old person, who:

. . . . *can't recall what he did with his funds or their source or amount, forgets to eat, is either afraid to spend his money, or else squanders his funds; or is constantly moving from place to place; or wanders the streets in the dark of night and forgets where he lives or has no permanent living quarters; or spends his money on liquor and begs or starves until his next check is received; or is living in squalor in a building that has been condemned but not yet torn down, is using an old portable oil burner for heating and cooking because the gas and electricity have been turned off; or crippled by arthritis and partly bedridden, continues to dwell in his own vermin-infested house by reason of accumulated rubbish and rotting food remnants; refuses hospitalization for treatment of infection resulting from untreated injury; or is constantly picking quarrels with the neighbors, shouting obscenities at passers-by, using an open window as a garbage disposal unit, dressing bizarrely; or continues to operate a small neighborhood store with entangled business affairs; or is in imminent danger of sustaining grave personal injury by reason of infirmity but refuses to leave home and will not accept any help within the home.*

Levitt quotes Goldfarb as saying, in respect to the kinds of older persons who present protective service problems, that ". . . In short, they defy our omnipotence, rip holes in our omniscience, show no promise of being grateful, do not stimulate or excite us and constantly threaten to dirty our clean skins, clothing,

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bill-of-health, and our own record of treatment successes." [2]

EFFECT OF TRADITIONAL DIAGNOSIS

If we were faced only with the problem of removing incapacitated older persons against their will from familiar surroundings and placing them in mental institutions, the dimensions of the problem would diminish, as would perhaps the problem of our own personal conflict. It would then become primarily a matter of clarifying legal remedies and procedures and assuring the availability of the required facilities. However, expanded knowledge about the adaptive capacity of older people and refinements in diagnosis and therapy suggest there may be alternatives to traditional approaches.

Cath refers to "certain basic anchorages that people form throughout life: (1) an intact body and body image, (2) an acceptable home, (3) a socioeconomic anchorage, and (4) a meaningful purpose in life. These four anchorages provide the structure within which the individual performs the required developmental tasks at various stages of life; and the degree of success with which tasks are performed and crises met spells the difference between good and impaired health." [3]

As Milloy points out, Cath is emphasizing the potential for strengthening the older person's functioning capacity, from which it follows that our concern must be not with pathology but rather with "those ego and life forces that are still intact or capable of restoration." [4]

Levitt indicates the danger in attempting to equate chronologic old age with impaired functioning and the "other so-called stigmata of senescence and senility . . . (Which) are by no means correlates." [5] Pointing out the wide differences among older patients in "appearance, skill, strength, endurance, education, occupation, intelligence and economic and social position," Levitt reports that "their particular physical and psychological illnesses run the whole gamut of social, medical, and psychiatric nosology . . . and that this is all too often, and incorrectly, attributed to "brain damage." [5]

Levitt cautions that the "traditional diagnostic categories of psychosis, psychoneurosis, character disorder, . . . that can be made are too often an indictment of the older person, especially when they are not measured against the assets and potentialities, the antecedent biography, the social and economic setting, the medical and surgical difficulties, the motives of all concerned with the patient, plus many precipitating agents and parameters which the patient and family cannot weigh properly." [5]

In trenchant and compelling terms—based on substantial study and observation—Levitt concludes that: "A knowledge of symptomatology is not as important as information about the modifiability and the medical, environmental, or emotional changes required. The double play of quick diagnosis, then disposition to hospital, commitment, nursing home, or guardianship is interfered with by such an attitude. It is medieval to think of a psychosis at any age as a problem of competency or confinement, just by virtue of a diagnosis. There are as many kinds of senescent problems as there are people with such problems." [5]

"A psychiatric patient must sometimes feel like a pea in the old shell game. One doctor puts him under one walnut shell called psychotic depression; the next shoves him under paranoid schizophrenia. Sometimes he goes behind a thumb called psychoneurosis and leaves the hospital." [6]

Similarly, when the patient's mental condition has a physical base such as brain damage due to arteriosclerosis, one physician may diagnose it as a physical condition calling for placement in a nursing home, while another doctor may term it a mental condition calling for placement in a mental institution. The diagnostic label should not be used as the determining factor in deciding whether or not placement is indicated, or the nature of the placement to be made when placement is indeed indicated. The problem is further complicated by the existing pattern of financing care as well as by the quality of care being rendered at any given time in the different institutions.

Levitt points to the ". . . basic divergency in concepts about the aging process, not only in the eyes of the law, but also among those in other professions. One of the components is our pragmatic, obsessional need for things to be black or white, our resistance to the idea of unconscious motivations, both in ourselves and in the needy elder. Added to this is the very real fear of our own capacity in the years ahead, which makes us react in a variety of ways to the patient" [5]

Goldfarb confirms that "a very large number of chronologically aged persons need much the same type of psychiatric services, chiefly for affective disorders (depression), as do our middle-aged and young adults," and that these groups have essentially the same kinds of emotional problems.[7] He adds that psychotherapy, with an equal weighting given to physiological and

environmental losses as to dynamic factors, can effect change, redirection and rehabilitation of older persons.[8 9]

GUIDING PRINCIPLES: GENERAL

While we have much to learn about the psychodynamics of aging there already exist sufficient phenomena to serve as a basis for setting forth certain principles or guidelines which may serve as a frame of reference within which to build the infrastructure—including essential law—to meet the protective needs of older persons.

The following are reference points for consideration:

1. We should acknowledge the right of the incapacitated older person to remain in the community for as long as possible and to manage his own affairs as well as he can and even to dress and behave bizarrely so long as his behavior does not constitute a danger to himself or to others. We should not only tolerate his right to stay where he is or be where he wants to be, but we should also extend to him such help as he may require to achieve this objective.
2. Our concern in protective services should relate to those older persons who, whether by reason of physical infirmity, mental illness, or both, are so incapacitated that they cannot, unaided, properly care for themselves or manage their affairs to the point where their inability to do so, even with supportive help, is likely to place them in a position of self-danger, or where the community is endangered by their continued presence.
3. Incapacity must be seen in relation to the behavior pattern, treatment needs and management requirements of the particular individual at any given moment, and not as a conditioned response to a diagnostic label. Outside intervention may or may not be required to compensate for such deficiency.
4. Incapacity is not a static condition, for it may come on gradually or it may be sudden, perhaps precipitated by the death of a loved one or through physical injury.
5. Progression from a condition of incapacity to varying degrees of capacity is a known phenomenon among some elderly people.
6. A wide range of diagnostic, treatment, and management facilities and services, institutional and community-based, is required for older persons who need or are presumed to need protective services.
7. Case finding, including the need to assure early treatment for those with incipient illness, is an essential component of a protective service, particularly as it relates to older persons who live alone and who are without family or friends to look after them.

GUIDING PRINCIPLES: LEGAL

Legal authority is an indispensable prerequisite to the provision of adequate protective services. Law serves as the basis for conferring authority to act for an incapacitated older person, with due regard to his individual dignity, his right of decision, his constitutional liberties, and his civil rights. Protective service law should therefore incorporate the following:

1. Immediate emergency action for either the person or the estate when recourse to court orders is not possible.
2. Temporary screening services to facilitate appropriate diagnostic evaluation and development of an adequate treatment plan.
3. A clear definition of the group affected by the particular statute or statutes; assurance that an overriding consideration will be that of functional capacity rather than diagnostic classification; a clear statement of the kinds of evidence to be required, including evidence as to social functional capacity as well as relevant medical and psychiatric factors; and, specificity as to the nature of the hearing procedures to be established.
4. The fullest range and specificity of placement facilities and services as required, and flexibility in placement to allow for transfer from one service to another when indicated.
5. Specific reference to those individual civil rights which may be adversely affected by the legal proceedings, so that it may be clear that the individual will maintain the right to exercise certain of his civil rights unless expressly limited in the legal proceedings. Where estate guardianship is involved, a further needed requirement is delineating guardian's authority with respect to the individual's assets.
6. Specific provisions for delineating the authority of guardians and custodial authorities, includ-

ing such matters as use of experimental drugs, radical surgery and other unusual medical procedures.

7. Separation of guardianship laws and procedures for older persons and their estates from State laws providing for guardianship of "minors, decedents' estates and incompetents." This recognizes that older persons' procedures are of a distinctive nature essentially rooted in the uniquely different problems presented by an older incapacitated person including the dynamics of ego psychology as related to the aging.
8. Appropriate provision for automatic and continual review of discretion exercised by the guardian and/or custodian in providing care and supervision for the individual.
9. Provision for periodic reassessment to determine whether changing conditions or circumstances require modification of the original decision as to commitment or guardianship.
10. Provision of adjunctive services to the court in respect to determination to commit, use of community resources, help in financial management or planning, discharge, followup, review and reassessment, accounting and estate appraisal and related matters.
11. Appropriate provision for termination of guardianship and/or commitment, return to the community and full restoration of all civil rights.
12. The right of the individual to legal counsel at every step, including appeal, due process and assurance of the full legal rights.
13. Provision for voluntary fiduciary and commitment procedures including adjunctive professional consultation services to minimize crisis situations.
14. Assurance of confidentiality of proceedings including impounding of court records and privacy of hearing.
15. Provision for appointment of public guardians, counsel, guardians-ad-litem, and waiver of costs with respect to persons with minimum assets.
16. Establishment of non-court-structured fiduciary relationships with respect to estates of limited value which would authorize specified persons of agencies to receive and disperse, on behalf of the older person, assets up to a designated maximum.
17. Where placement is in a nonpublic hospital, clear statement as to the nature and extent of the supervisory authority lodged in a designated State agency.
18. Provisions for accountability with respect to institutional facilities.
19. Provision for authorizing governmental and voluntary agencies and institutions, including public welfare departments, to serve older persons requiring protective services, incorporating authority for the agencies' staff to petition for appointment of a guardian of the property or the person, or both, and for commitment to a public mental hospital or any other placement facility or service authorized by law. [5 10 11]

"Since law in the end always deals with human beings, there would seem to be almost no area in which the influence and findings of the social and behavioral sciences might not be used to explain and improve the law in its daily operation upon the members of our society." [12]

Social workers, for example, must understand the degree of certainty required with respect to predictability of human behavior based on observations and that the law cannot be rewritten to reflect knowledge based on behavior which is too indefinite. There is a corresponding need on the part of lawyers to apply their knowledge of bureaucratic structure and legislative and administrative practices to reflect in law what social work and medicine can demonstrate to be warranted.

GUIDING PRINCIPLES: SERVICES

To give meaning to the law, it is imperative that community-based protective-service agencies be established and armed with authority to assume the responsibilities of a protective service function.

To give full meaning to *legal* protective services, we must acknowledge the interrelatedness between preventive and supportive services and protective services which include legal sanction and authority. We must establish a total, comprehensive program which includes a constellation of interrelated services and facilities, equipped to deal with the varying needs presented by all older people who need some kind of protective care.

Each community will have to decide for itself, in relation to its own pattern of organization of services and its own needs, the form in which a protective service function should be structured. Hemmy recommends that such a program be based on the assumption

". . . that all actions taken are directed toward supporting and maximizing such capabilities as the individual has for decision-making in his best interests, that he be helped to participate to the extent he is able in the decisions reached, the plans made and the actions taken; that no part of the independence of which he is capable be taken from him. Emphasis is placed upon enabling him to remain in the general community, if possible, with such counseling, supervision, guidance and supportive services as may be needed. Initiation for commitment to a mental hospital is undertaken only when such care is essential." [5]

Lehman suggests five stages in agency protective service programs for the aging: [10]

1. Reaching the client in order to make needed services available to him.
2. Physical-psychological-social diagnosis so as to understand the client and his environment.
3. Making a plan related to the diagnosis "taking into account the wishes of the individual to the greatest extent possible, allowing for the maximum personal freedom of action and responsibility of which he is capable, and involving the family and close friends wherever possible."
4. Implementing the plan with or without the consent of the individual or the family, as necessary.
5. Continuing active in the case, and modifying the plan if, as and when indicated, by changing circumstances or conditions.

Lehman's points also suggest:

1. Social casework is the core of a good protective service. The skill of the professional social worker in social diagnosis and his intimate working knowledge of community resources, coupled with ability to use them creatively in relation to the older person's needs, constitute the base upon which flexible and comprehensive planning can be achieved.
2. The agency must be structured in a manner which facilitates and furthers its capacity to act authoritatively, armed with legal protection and sanction, supported by board and community and, in turn, supportive of the social worker in whatever action the exigencies of a particular situation may require of the worker.
3. Prevention and rehabilitation, to the extent that they are a realistic possibility in the individual situation, should be primary goals of the service.
4. The service must be available at all times and at any hour of the day or night.[10]

The American Public Welfare Association asserts that ". . . there is considerable and growing pressure on State public welfare agencies to assume full responsibility for acting on behalf of a client who is unable to manage his affairs, particularly when other resources are exhausted or unavailable. The APWA believes that this is an appropriate role for public welfare agencies to assume." [13]

Winston expresses her belief that ". . . public welfare agencies should ultimately be able to set up much more comprehensive programs of protective services," adding that . . . "The agency and its staff would need security in acting in behalf of others and protection against liabilities they might otherwise incur by taking forceful action. . . ." [5]

Whatever the structure assigned local responsibility, it is clear that the voluntary family service agencies must assume a greater degree of responsibility in serving older persons. Wasser points out that a 1960 study of family service agency applicants indicated that the aged constituted only 3 percent of the applicants although they represented more than 9 percent of the population.[14] Those aged who did come to the agency received an average of 1.4 interviews against an overall average interview count of 6.7 per client.[15]

Conclusion

Planning a community protective service program, including staffing requirements and cost, becomes difficult in the absence of definitive information as to the dimension of need. Estimates range from half a million old age assistance recipients, 20 percent of the caseload,[16] to 5 to 10 percent of the noninstitutionalized urban aged group.[17] Larson reports great variation in the overall estimates of how many older people are showing enough confusion and disorientation, or are otherwise lacking in capacity, to be likely to be in need of community protective services (ranging from about 5 to 15 percent of the population over 65).[18]

In estimating that there are at least 300,000 adult Social Security beneficiaries under the Social Security Administration's representative payee program, of whom there are 100,000 age 62 and over. Larson adds ". . . this figure is an underestimation of the total number of persons 62 years of age and over who are, in fact, incapable of managing their benefit funds," and

based on sample studies, she concludes ". . . there are probably 80,000 aged persons 62 and over who should have the protection of representative payment and do not have it, almost 80 percent of whom are 72 and over." [18]

Goldfarb states that ". . . suggestions for meeting the needs of aged persons are often determined by social values which are unwittingly shaped by what appear to be practical considerations of community energy, time or money . . . . The need for protective services is usually underestimated, and (the) need (of the aged) for psychiatric attention as a part of such care is always underestimated," and concludes that ". . . many aged persons can find no place which can give them the protection, supervision, the general medical and special medical—including psychiatric—care, for which they have great need." [7]

Our present inability to pinpoint the size of the group affected should not seriously interfere with the planning of a community protective service program. If we will free ourselves from earlier meanings of diagnosis and relate to our total knowledge of human behavior, if we provide legal guideposts consistent with this knowledge, and if we are sensitive to an older persons's changing needs—we will then create appropriate protective safeguards.[15]

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COUNSELING WITH OLDER PEOPLE AND THEIR FAMILIES

by
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The central dynamic of aging is the struggle to cope with loss of important relationships, health, sense of usefulness and self-esteem. In order to reverse the person's sense of helplessness which deepens as losses compound, effort should be made to involve the aging person in planning for himself, even though he may need the help of others to carry out his plans. As older people lose their family and personal relationships, and as their sense of isolation increases, they often transfer dependency to persons in their environment who provide them with services essential to their survival.

Older people develop relationships at different rates, just as younger people do. Some will relate more closely than others. Relationships of social caseworkers with the older person must include those family members, friends, physicians and significant others who are involved actively in his life.

THE REQUEST FOR HELP

The request for help for an older person often comes from a relative who is concerned about him and who may be reacting to his own sense of loss of the relationship with the older person as it existed in the past when it was meaningful to him. Many requests come at the point of a crisis. Prompt attention is important, but precipitant action which includes uprooting the older person from his familiar surroundings should be avoided whenever possible. The community should maintain a range of supports which enables people to remain in their own homes until they require services which cannot be provided at home.

Many older persons need help in obtaining companions and housekeepers. There is an inadequate supply of the right kind of housing at the right price. Social agency services may not be readily available when needed. There is insufficient knowledge of available community resources. Many of the poor aged have no telephones.

Sources of Help Requests

Most counseling agencies find that the request for help to the older person often comes from relatives. Frequently the request is made without the knowledge of the older person. The applicant is often uncomfortable about a request for help and feels he is somewhat inadequate because he has been unable to solve the problem through his own efforts. Sometimes the family postpones requesting help long beyond the point when it might have been most effective. Often they are fearful that an agency will not understand either the older person or them, and may move toward a separation of the older person from his home and family which they are struggling to avoid. Often the expenses required to maintain the older person have constituted an undue strain on the resources of a young family. Sometimes the young relative is not able physically or emotionally to provide the care the older person requires.

The physician, a friend or the older person himself may on other occasions be the referral source. Referrals from other agencies are minimal.

FOCUSING THE RELATIONSHIP

The caseworker considers it his first task to get to know the *person with the problem.* This includes developing a relationship with the older person as well as those family members and friends who are actively

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involved in his life. The concept of planning *with* the person rather than for him often is difficult for families and even for other professionals to accept. In their minds, the request for outside help is necessary only because the older person can no longer solve his problems through his own efforts. The caseworker proceeds with the conviction that every human being wishes to operate to the maximum of his capacities throughout his life, and that this wish does not diminish or disappear as one's physical and emotional resources dwindle.

Reactions to Loss

As has been noted, the central dynamic of aging is the struggle to cope with loss. To cope with this loss and the anxiety it engenders, the individual not only employs his usual defenses against anxiety, but often acquires some new defenses in a desperate effort to protect himself against further hurt. It is for this reason that the older person sometimes appears walled-off and impervious to further onslaughts from the environment. Behind this mask, however, is the frightened individual, trying desperately to hang on and to protect himself. The caseworker recognizes this and moves slowly and gently. He tries, through his manner, to convey that he wants to understand the older person's anxieties and his struggles to cope with his fears.

The caseworker's first task is to make contact with the older adult client. Sometimes this is achieved by commenting on some object in the room or house which seems to have particular meaning to the older person, such as the well-cared-for plants, his well-read books, a figurine in a prominent place, a piece of jewelry, a picture on a nearby table. Often the older person can talk more easily about these important objects than he can about something significant about himself. This can be the beginning of a bridge to him which will lead to the relationship necessary to help him with his current concerns.

Sources of Information

At times, it is difficult to gain enough information from an older person to ascertain how he is managing the tasks of daily living. Does he have any relatives or friends? Does he have a church connection he values? Does he have a doctor whom he sees with any regularity? What are his financial resources?

As people lose their important family and personal relationships on which they have depended the most, and as their sense of isolation increases, they usually transfer their dependency to those persons in their environment who can be counted on to appear regularly and to provide them with some important small service that is essential to their survival such as the milkman, the grocery boy, the elevator operator, the postman, the newspaper boy, the delivery boy from the pharmacy, a neighbor, or some small boy in the neighborhood who runs errands. It is the grocer who knows what the older person has been eating. It is the druggist who knows what medicines have been ordered and by whom. It is the milkman or postman who often is the first to notice that the person is unable to get to the door. In order to reconstruct the older person's life, the caseworker may need to contact some of these persons who provide the environmental and emotional supports which keep the person alive.

In all this behavior one can observe the struggle to maintain oneself and one's identity, even in the face of the most painful losses.

PROMPT AND CAREFUL EVALUATION

Many requests for help have long been postponed; when they finally are made, it is important for the counselor to move quickly to establish a meaningful contact with the older person and his family. What needs to be guarded against, however, is precipitant action before the situation is understood sufficiently. It is particularly important to avoid uprooting the older person from his familiar surroundings without careful preparation for such a move. Sudden shifts undermine the person's defenses and create so much anxiety that personality deterioration may result. Sometimes a medical emergency or even an environmental event, such as a fire in the apartment, makes it necessary to move the older person without warning or preparation, but when these occur we should anticipate and help others to understand the kind of disorientation which may occur as an immediate reaction to sudden uprooting.

Miss R.'s attorney asked the agency to plan with Miss R., a 90-year-old woman who had refused to remain in the institution for the aged where she had been placed by relatives a month previously. Her physician had suggested she enter the hospital for tests after she had complained of a backache for several weeks. It was found that she had a calcium deficiency of the spine which would require her to wear a body-brace and to limit going up and down stairs to once a day. Relatives then arranged for her to enter a sectarian home for the aged by mortgaging her property in order to pay her admission to the home. At the institution Miss R. was placed in the hospital section where she

could not adjust to strangers coming in and out of her room at will. When it came time for Miss R. to sign the permanent contract at the institution, she rebelled and went home.

The caseworker first saw Miss R. at home, shortly after she had returned there. She felt betrayed by friends and relatives. Through weekly visits, Miss R. began hesitantly to give information about herself. Miss R's physician confirmed that she was not in need of nursing care.

Miss R. gradually developed a warm and trusting relationship with the agency caseworker, who was able to persuade her to accept help in employing a woman who prepares Miss R.'s breakfast, assists her with her dressing and then leaves. Because Miss R. was reluctant to use her last capital to finance this help, the agency met this cost, and Miss R. signed a statement to the effect that the agency is to be reimbursed for this amount from her estate at the time of her death. In addition, Miss R. has been able to accept the services of an agency volunteer who visits her weekly and supplements the friendly interest of the agency caseworker. Miss R. has requested that the agency begin correspondence with a nephew in Philadelphia who is the only relative she really trusts.

This situation illustrates graphically why it was unsound to try to uproot this woman from her environment to which she had strong meaningful ties. At the same time it demonstrates that Miss R. could not have continued in her own home, except with the help of the caseworker and the agency, which made it possible for her to have the household help and emotional support she must have at this age.

THE IMPLICATIONS OF THE DIAGNOSIS

Case workers need to understand the implications of the medical diagnosis in order to understand what they are observing in the patient's behavior and what to expect. If his attention span or performance span are shortened, he will be unable to tolerate an hour's interview. If he has experienced a memory change, he may forget that the caseworker is coming to see him, the content of their last conversation and what he has already discussed. Caseworkers often are more alert to the effect of physical handicaps such as deafness, defective vision and crippling, than they are to the effects of diseases which bring about brain changes or loss of energy.

When aging is complicated by organic brain changes, the caseworker proceeds differently than when the problem arises from a physical disability which does not involve organic brain changes. Mrs. C. illustrates this.

Mrs. C.'s daughters consulted the agency because of their concern about their 82-year-old mother who was insisting on continuing to live alone, even though she was very forgetful. On the caseworker's first visit to Mrs. C. she found her in constant motion—rocking, walking about, moving her hands and talking incessantly. At one moment she was gay and the next crying. She had no memory for time, dates or specifics. The one point at which the caseworker was able to make contact with Mrs. C. was around her loneliness. Mrs. C. mentioned that since the death of her husband and mother, and more recently her cat, she sat in the house alone.

When the caseworker consulted the physician, she learned that Mrs. C. had advanced arteriosclerosis, hypertension and cardiac failure. She refused the medication prescribed for her because she said it did not help her. He advised she be admitted to a nursing home, if she were unwilling to live with one of her daughters.

As the caseworker consulted with the daughters she found them quite hostile toward their mother. They were unable to accept the fact that their mother was changing, and instead were attempting to appeal to her reason to get her to operate in a more rational fashion. The caseworker listened to the daughter's complaints and then pointed out gently that their mother was a changing person. They became angry with her because it was difficult to accept the fact of this change. The best approach was to be firm and gentle, for argument made their mother more defensive.

The caseworker offered regular visits to their mother, but urged that they arrange a medical evaluation at that point, and that they share with the physician what they were observing in their mother's behavior. Inasmuch as their mother seemed financially irresponsible, the caseworker urged that they consider asking their lawyer to act as guardian or to take power-of-attorney, and that they give her one dollar bills rather than bills of larger denomination. She clarified how they should proceed in obtaining an evaluation of mental illness or incompetency.

The caseworker then talked with Mrs. C. about going to live with one of her daughters. Mrs. C. did not wish to barge in on any of her children. It was pointed out that she had been a good parent and had taught her children to be responsible. A good parent also lets her children help her, and her children wanted to help her by having her live with one of them. Mrs. C. then agreed to go to live with one of her daughters.

Mrs. C. has continued to live with her daughter and to respond positively to having her dependent needs adequately met. In addition, her daughter is able to supervise her medication and diet, with the result that Mrs. C.'s health has improved.

SHORT-TERM RELATIONSHIPS

A continuing relationship serves the purpose of helping the person to have something which sustains while much of his life experience is changing and many of his relationships are terminating. Yet there is an equally important function of a short-term relationship for some older persons.

Such help is particularly acceptable and appropriate for persons who have demonstrated strengths in their capacities to solve problems throughout their lives. When they bring themselves to request help from others, they want the provider of services to recognize their independence and their capacities. Such older persons often can use help better at intervals rather than on a continuous basis. They are reassured by the caseworker's recognition of their ability to carry on between contacts without outside help. Some of these older persons also enjoy the responsibility of providing some volunteer services to a community program, as this is tangible evidence of their continuing adequacy.

Other older persons who use short-term services more easily than continuing services are those who shun close relationships and feel more comfortable when they maintain some distance in their relationships. Some are reluctant to commit themselves to an indefinite plan for service and prefer a time-limited arrangement.

People of all ages wish to make decisions for themselves, once they have demonstrated their ability to do so. They expect to seek expert counsel on matters on which they are uninformed, but they do not anticipate that this will commit them to a plan for continuing relationship with an outsider. If caseworkers are to make themselves useful to these older persons, they must respect their wish to separateness and their reluctant decision to accept help. Miss B. is such an example.

Miss B., aged 72, telephoned the agency to talk with someone regarding future plans for herself. As a retired school teacher, she had managed well in the family home until she suffered a detached retina several months previously. She was fearful that her other eye might become similarly affected and that this would necessitate her making different plans for her life. She wanted only information regarding philanthropic homes and was reluctant to discuss anything about her concerns.

The caseworker recognized that it must be a special problem to Miss B. to be unable to read, because much of her life had been devoted to reading. Miss B. seemed relieved when the caseworker perceived what this might mean to her. The caseworker recognized that Miss B.'s call for help was prompted by a mild panic following surgery which involved a loss of vision during her convalescence.

Once Miss B. was reassured that the caseworker knew community resources and could help her to avail herself of these if she needed to, she relaxed, and could recognize that she had panicked when confronted with the possible loss of her eyesight. The caseworker recognized that Miss B. was fearful of close relationships and anxious to remain independent. Miss B. was assured of the agency's continued interest in her. Two years later she telephoned the caseworker so as to obtain a resident companion.

The agency's acceptance of this person on her own terms undoubtedly will enable the client to use a continuing relationship and help from the agency should this become necessary at a later date.

SUMMARY

In serving older persons, social caseworkers must be sensitive to the individual differences of their clients and must have access to a range of services appropriate to their varying needs at different points in their lives. Older persons are more capable of changes than is generally understood.

To the extent that it is understood that older persons often prefer to participate in all aspects of plans which concern them and prefer to contribute in a meaningful way to the solution of their problems, practitioners demonstrate their confidence and conviction in the flexibility and enduring capacities of the human personality. When this is not understood, rigid and inflexible patterns of service emerge, making it difficult for older people to obtain the most appropriate service for themselves, their families and their community.

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HEALTH CARE SERVICES

by

Anthony Lenzer*

How well are old people, and how likely are they to maintain health throughout old age? While not as healthy as the young, most are, for all practical purposes, quite healthy and are likely to maintain this state of health until very near the end. Many members of the helping professions find this statement difficult to accept.

Some reject the claim because they themselves are illness-oriented. They define health as the absence of clinical pathology. Seen this way, old people are indeed sick, and the older they get, the sicker they become. Eighty-six percent of persons over 65 have at least 1 chronic condition. When one adds acute illness and accidental injuries, practically every old person has something wrong with him.

Other professional workers reject the statement because it contradicts their own experience. Most of the aged persons whom they are trying to help are ill, frail, disabled or dependent. They assume their clients are typical of old people, but in reality they are atypical. The old do not usually turn to community agencies for help until they, their families and friends can no longer cope with a problem. By that time, the problem is serious and complicated.

In this paper, health is defined as the ability to function well enough to carry out normal roles and responsibilities in the community. This definition has several advantages: it is relatively easy to determine how well people are functioning; it directs attention to conditions within the individual or environment which, when corrected, will improve functioning; and, it makes sense to the aged themselves, if not to professionals.

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HEALTH STATUS OF OLD PEOPLE

In these terms, old people seem to be pretty healthy after all. The National Center for Health Statistics indicates that only 5 percent of persons over 65 are so ill or function so poorly that they must live in nursing homes, homes for the aged, mental hospitals or other institutions. Even at age 85, 8 out of 10 persons are still living in their own relatives' homes and *not* in institutions. But how well do the noninstitutionalized aged function? Chronic or long-term conditions are the major source of disability for old persons, and 85 percent report at least 1 chronic condition. Yet only 14 percent of the noninstitutionalized aged report that they are totally unable to work or keep house due to a chronic condition. An additional 25 percent can work but are somewhat limited in the amount or kind of work or house work they can undertake. Even at age 75, only 24 percent are totally limited and 30 percent partially limited in work capacity because of chronic illness.

One additional measure of health is the number of days per week in which the person has restricted activity or is confined to bed. This measure of "disability days" counts *all* such days, whether due to chronic illness, acute illness or accidents. National Center for Health Statistics data indicate that old people have more disability days than young or middle-aged people. But even

the old are, on the average, restricted in activity only 35 days per year and are confined to bed on only 12 of these days.

Despite this encouraging view of the health of the aged, there are aging process realities to be considered.

MAJOR HEALTH PROBLEMS

Two types of health problems are considered here, namely, the main causes of health and disability and the barriers which stand in the way of maintenance of health and control of illness.

Main Causes of Death and Disability

Three-fourths of all deaths among persons over 65 are due to heart disease, stroke and cancer. Diseases of the heart are by far the most important cause of death. Within this category, arteriosclerotic heart disease (including coronary heart disease), claims the greatest number of victims. The following table lists the leading causes:

CAUSES OF DEATH FOR PERSONS 65 AND OVER, U.S., 1965

Cause	*Rate per 100,000 population*
Diseases of the heart	2,823.9
Cancer	901.4
Stroke	901.0
Influenza and pneumonia	213.7
General arteriosclerosis	198.9
All accidents	155.0
Diabetes	122.9
Other diseases of the circulatory system.	97.4
Other bronchopneumonia diseases.	47.3
Other hypertensive diseases	47.3

SOURCE: National Center for Health Statistics, *The Facts of Life and Death*, Washington: U,S, Government Printing Office, 1965, PHS Publication 600, Revised 1967.

Heart conditions and arthritis and rheumatism cause the greatest amount of disability, as the following table shows:

PERCENT OF NONINSTITUTIONALIZED PERSONS 65 AND OVER LIMITED IN ACTIVITY DUE TO CHRONIC CONDITIONS, U.S., JULY 1963–JUNE 1965

Condition	*Percent of old people who are limited as a result of that condition*
Heart conditions	22%
Arthritis and rheumatism	21%
Orthopedic impairments (excluding paralysis or absence of arms, legs, back, spine or hips).	11%
Visual impairments	9%
High blood pressure	8%
Mental and nervous condition.	6%
Genitourinary conditions; paralysis.	4% each
Diabetes; asthma and hay fever; hernia; hearing impairments.	3% each
Varicose veins; chronic sinusitis and bronchitis.	2% each
Neoplasms (cancers); peptic ulcer.	1% each
Hemorrhoids; tuberculosis	less than 1% each

SOURCE: National Center for Health Statistics. *Chronic Conditions and Activity Limitation, United States, July 1963–June 1965*. Washington: U.S. Government Printing Office, Publication Series 1051, February 1969.

Further, on any given day, approximately 2 million aged people experience the effects of injuries, two-thirds of which occur in the home.

Barriers to Health Maintenance and Illness Control

"Potential" barriers become "real" to the extent that the old lack the skills or energy needed to overcome them and communities fail to provide necessary help. Barriers within old people, health practitioners, the health care system and society may keep the aged from obtaining health services.

Some aged people believe that symptoms of illness are normal and inevitable results of aging and therefore do not seek help. Others are aware of their need for help

but lack the knowledge or energy required to reach available services. The poor and poorly educated lack skills needed to manipulate the system to their advantage.

Health professionals in general are oriented toward acute illness or the acute phase of chronic disease and have limited experience in management of long-term conditions. Some feel that they have little to learn from an old patient and that they cannot do much about his problems. Increasing demands for health care result in more pressure upon practitioners, who in turn give low priority to the needs of the aged.

The term "health care system" implies an unreality, namely, that most communities have an integrated network of health services and facilities and someone doing planning to meet health needs of the population. Most communities contain many services and facilities which offer potential aid to the aged person. Yet few have any mechanisms for assessing patient or family needs, determining how and where such needs can best be met, and helping people obtain the appropriate services. Some practitioners are willing and able to perform these time-consuming "medical management" functions, but many are not.

The autonomy of providers of care is another barrier. Most agencies are independently administered, and the linkages between them are fragile or nonexistent. Because old people need a variety of services, they must knock on many doors to obtain help. Many health agencies define their mission in a rigid, narrow fashion and vigorously defend their territory against real or imagined encroachment by others. Fragmentation of information about the patient often occurs when he receives service from different agencies. Finally, the system creates particular hardship for old people in small towns, rural areas and the inner core of large cities. These are precisely the areas with the greatest shortages of health resources.

The major social factor affecting access to health services is the generally low social valuation of the aged compared with other age groups. When resources are scarce relative to demand, aged persons and other low-priority groups will be the last to receive them. Negative social valuation is reinforced by the fact that many old people are not only old but are also poor and ill educated and thereby possess low social status.

UTILIZATION OF HEALTH SERVICES

Various factors influence the extent of use of health resources by any segment of the population. These include the health status and needs of the groups; availability and accessibility of resources; knowledge of, and attitudes toward these services and facilities; beliefs about prevention and cure of illness; ability to meet the cost of care; the nature of the restrictions placed upon use of services by the providers; and the help which is available for effective use of the system.

Currently there is great interest in Medicare's impact on use of health services by the aged. National Center For Health Statistics data, comparing the first year of Medicare (July 1966–June 1967) with the previous year, indicates that discharges of old people from general hospitals increased 11 percent in the year following enactment, and the average length of stay in the hospital increased 9 percent. On the other hand, the percent of old people who contacted a doctor at least once remained approximately the same, as did the number of contacts per person per year. In fact, doctor visits in the first year after Medicare dropped slightly, probably reflecting the low incidence of influenza and other acute conditions during 1966–67.

The following statistics indicate what happened during the first year (1967) in which the full program was in operation:

UNDER PART A—HOSPITAL INSURANCE	
Number of claims paid for:	
(a) Inpatient hospital care	5,215,631
(b) Outpatient hospital diagnostic services.	562,295
(c) Home health services	327,103
(d) Extended care facility care.	740,000
UNDER PART B—MEDICAL INSURANCE	
Number of bills paid for:	
(a) Physicians services.	20,166,565
(b) Home health services.	367,395
(c) Outpatient hospital services.	2,546,858
(d) Independent laboratory charges.	339,512
(e) All other services	655,235

All told, Medicare paid over 31 million claims and bills, at a cost of more than 4.5 billion dollars. Medicare therefore promotes utilization of health services by providing funds with which old people can purchase various health services, and by encouraging practitioners and agencies to expand or develop new services.

TYPES OF HEALTH SERVICES

In general, health services for old people should be comprehensive, coordinated, and continuous.

Comprehensive Health Services

Comprehensiveness means that a total range of services is available and accessible to meet all known needs of the old person and his family. These include: (a) health promotion; (b) prevention and detection of illness; (c) ambulatory care; (d) hospital and other institutional care; and (e) home care. They also include: (f) evaluation of the patient's status and needs; (g) counseling and referral to sources of help; and (h) continuing surveillance so that care plans change as needs change. In addition, they should include: (i) help in restructuring family, job and avocational plans; and (j) emotional support over the months or years that illness or disability persist.

Coordinated Health Services

Coordination means that services are assembled into an appropriate package for each individual. When several agencies are involved, it is sometimes difficult to reach full agreement on what the package should contain. Other problems arise when the practitioner understands some patient and family needs but ignores others. Planners of care create additional problems by trying to fit the needs of the patient to the resources they are familiar with instead of finding resources to fit needs.

Continuous Health Services

Continuity means that services are provided without interruption. Continuity should be assured whether patients are brought to services or vice versa; whether one receives all services from a single agency or a number of agencies; and whether care is financed through one or several sources.

PREVENTION OF ILLNESS AND DISABILITY

Preventive services should aim for the maintenance or development of healthful living habits, elimination of sources of illness or injury, and protection against their hazards.

Healthful Habits

The following habits are important to health maintenance in old age: eating in such a way as to meet all nutritional requirements while avoiding overweight; exercising regularly to maintain full functioning capacity; getting enough rest to wake refreshed and function well throughout the day; correcting minor defects which could reduce ability to walk, talk, eat, see or hear; avoiding or eliminating cigarette smoking.

Eliminating Hazards

Environment includes the immediate environment of the home as well as the larger social environment. Many home accidents could be prevented by changes in the structure or arrangements of the home. Home safety inspections by firemen, building officials or neighborhood aides might help sensitize old people to home hazards. Groups or classes on home safety might also be helpful.

Within the home, increasing illumination levels, using large readable labels on containers of hazardous products, and keeping electrical and gas equipment in good repair all serve to protect the old against hazards. Installation of air conditioning can also be beneficial. Recent studies of heat waves show the aged to be the major victims.

Air pollution and unsafe crossing zones on busy streets are two types of social hazards to be removed so as to benefit old people. Heavily polluted air has been shown to cause excessive illness and death among the old; poorly regulated traffic strikes down the old as well as young.

Detection of Illness

Health workers believe that early detection followed by correct diagnosis and prompt treatment reduces the likelihood that a disease will lead to disability or death. This requires that the condition be discovered prior to the time when the average person becomes sufficiently alarmed by symptoms to go to a doctor.

Three principal methods of early detection are periodic health exams, screening and sensitizing people to symptoms.

Periodic Health Exams. Health exams include a health history, "physical," and whatever laboratory work the physician feels is indicated. The physician gives the physical, interprets findings and gives instructions as necessary.

Periodic exams have their greatest value when they are comprehensive and are done by the same physician throughout the person's lifetime. Under these

circumstances, the physician has a baseline (information on what the old person was like as a young and middle-aged adult) and an accumulation of data on which to base judgments. However, relatively few adults have regular exams, and they are rarely of the type suggested.

Screening. Screening is the use of simple tests and procedures for rapidly discovering signs of illness in large populations. Theoretically, at least, screenees should be unaware of the presence of illness and should believe that they are in good health. Screening can be aimed at uncovering one condition or several possible conditions in "multiple" or "multiphasic" screening.

While screening has the virtues of being fast, inexpensive and applicable on a mass basis, it also poses difficulties. For example, a number of the serious chronic conditions cannot be detected by known screening tests. Neither has it been scientifically established that most existing screening programs lead to significantly reduced disability or death rates. Apparently it is of *proven* value for only a limited number of conditions such as anemia, cataracts, otitis, rheumatoid arthritis, hernia, TB, overweight and cancer of the uterus, bladder, skin, and mouth.

Sensitizing People to Symptoms

Another approach is to familiarize people to symptoms which may indicate the presence of certain diseases. The most extensive and oldest symptoms campaign centered around cancer's "Seven Danger Signals."

The basic shortcomings of the "danger signals" approach are the confusion likely to ensue if the public is expected to remember symptoms of even half a dozen serious diseases and the fact that by the time symptoms are apparent to the person, a disease may already be beyond the early stage. Then too, knowledge of symptoms per se is insufficient to motivate people to action.

EVALUATION OF NEEDS, COUNSELING AND REFERRAL

Old people have a great many health-related needs, and these needs change from time to time. Most urban communities have numerous health resources—*if* agencies imposed less formidable barriers to service, *if* they worked together more, and *if* there were someone to steer the individual to the right place at the right time.

Some communities have begun to realize how devastating chaos in the Health System can be for the long-term patient. They recognize the need for new types of personal health managers, planners and steerers. One solution is development of an Information and Referral Service for the chronically ill and aged. The IRS maintains a central file on all community health and welfare resources and makes information available to all who seek it; provides personal counseling for individuals and families; makes referrals to appropriate agencies and practitioners and follows up, if necessary, to see that service is given; and offers consultation to health agencies and planners regarding improvement of services to the chronically ill and aged.

AMBULATORY CARE

Even if prevention and detection systems were excellent, illness would still occur and old people would need diagnosis and treatment. Ambulatory care is primarily diagnosis and treatment which is given in doctor's offices, clinics or group health settings. Aside from medical care provided in hospitals or other institutions, about two-thirds of all physician contacts with old people are at the doctor's office. Approximately 9 percent of such contacts occur in hospital clinics and 8 percent are by phone. Seventeen percent represent visits by doctors to the old person's home. Old people have approximately the same pattern of contact with physicians as the total population, with one important exception: physicians visit old people at home three times as often as any other age group, according to 1963–64 data. To obtain care, the individual must be able to get to where it is given. At least on the surface, most old people manage to do so on their own or with the help of relatives, friends, or taxi drivers.

HOSPITAL CARE

The general hospital is usually seen as a provider of maternity care and inpatient care for persons with serious, acute conditions. Yet, the aged make heavy use of hospitals—they are hospitalized more often and stay longer than any other age group.

Hospitals today are concerned with the entire spectrum of illness, from its earliest to its last stages. Stimulated in part by Medicare, hospitals are increasingly establishing screening and diagnostic services and rehabilitation departments.

Some leaders in the hospital profession believe that these changes are just the beginning of the transformation of the acute hospital into a community health center in which public and private health activities, acute, chronic and psychiatric care would be available on a

single health campus. Whether this becomes the new pattern or not, the aged are likely to be among the chief beneficiaries of experimental approaches to the integration of health services.

OTHER INSTITUTIONS SERVING THE AGED

Mental hospital admission rates increase with age, as do mental illness rates. Yet the evidence suggests that most old people are mentally competent and they do not become irresponsible or befuddled in their last years.

Institutionalization for the Mentally Ill Aged

Where are the mentally ill aged? Recent national studies indicate that there are almost as many people with "mental disorders" in nursing and personal care homes as there are in mental hospitals. In 1963, there were approximately 167,000 old people in long-stay mental hospitals. In 1964, nursing and personal care homes contained 101,000 patients with mental disorders and 148,000 who were classified as senile.

Does institutionalization mean the end of the road for the aged? Not necessarily. A Public Health Service report on *Mental Disorders of the Aging* indicates that response to treatment by patients 65 and over is virtually the same as for other age groups: a third recover or nearly recover; a third improve considerably; and a third remain the same or grow worse. The trick is to get *treatment* for the old, rather than custodial care.

Old people should not be placed in mental hospitals or other long-term institutions until they have been given a thorough evaluation at an appropriate center. Evaluation provides the opportunity to ask: Why does the old person behave as he does? Can anything be done to correct this condition? Does he really need to go to the State mental hospital, nursing home or whatever other institution we had in mind for him? What alternatives might better meet his needs and those of his family?

Psychiatric units in general hospitals are often more appropriate places for treatment of the mentally ill aged than are long-term care institutions and should be used whenever possible. As of mid-1967, there were over 700 psychiatric units in general hospitals, and almost all of these were certified to provide services under Medicare. In fact, Medicare regulations encourage the use of such units in preference to custodial mental hospitals. General hospitals are more likely to have the specialized medical resources which older people need and are usually more accessible to friends and relatives. There is also less stigma and a greater sense of hopefulness associated with care in these institutions.

Nursing Home Type Facilities

Extended care nursing homes and homes for aged offer care and protection from the stresses of independent living when the aged become too ill, frail or dependent to manage on their own and when family members cannot or will not assume such responsibilities. These facilities vary enormously in their objectives, their names, ownership and administration, bed capacity, staffing, services, quality and cost of care. For an up-to-date analysis of facilities of this type, the reader is advised to contact the National Center for Health Statistics of the U.S. Public Health Service since there are rapid changes currently taking place nationally.

The *extended care* facility is a new type of facility created by the Medicare legislation. Its purpose is to provide short-term, skilled nursing and active, rehabilitation-oriented care for old people, following discharge from the hospital. The basic orientation of the ECF is quite unlike that of the traditional nursing home, which still has a custodial flavor and a passive approach to care. While the ECF emphasizes rehabilitation, the term has a somewhat different meaning than when applied to young people. For young people, rehabilitation usually means a return to the community, to school or to the job. For old people, it often means, essentially, prevention of further disability. The criterion for success is not return to "productivity," but the ability to care for one's own needs while making less demands on social resources.

It is hard to consider nursing homes and homes for the aged as two separate types of facilities, since many homes offer a mixture of skilled nursing and room, board and assistance in activities of daily living. Also, State licensing laws often fail to adequately distinguish between facilities on the basis of the services which they offer.

Nursing homes have, in general, improved greatly in recent years due to increased professionalism, licensing, accrediting and certification. Licensing laws have begun to include standards for nursing and other care and require certain minimum qualifications for personnel. By 1972, the States are required to establish minimum standards of training and experience for persons wishing to enter nursing home administration.

Accreditation is a further method for raising standards. Accreditation, unlike licensing, involves voluntary compliance with a set of standards which an

industry or occupation sets for itself or which is set by an impartial accrediting body. In January 1966, the Joint Commission on Accreditation of Hospitals agreed to serve as the accrediting body for nursing homes. Certification as an ECF under Medicare imposes still more quality standards on the institution.

Another approach is to devise more sophisticated systems for classifying old-age institutions. Such systems should take into account intensity and amount of service and the quality of care provided.

Traditional homes for the aged are nonprofit institutions sponsored by churches or fraternal organizations. They have served as homes for old people who, though physically well, were socially dependent and unable to maintain themselves.

Although the traditional type still exists, most homes have either become: (a) medical facilities for the physically or mentally ill; or (b) parts of larger institutional complexes which are designed to meet a wide range of needs. Such institutions frequently are affiliated with universities or medical centers and foster research and training in addition to serving the aged.

Adult foster homes serve people who, because of physical, mental or emotional problems, are unable to live independently, but who need and desire the security of family living. The foster family is expected to provide a family-like role.

Boarding homes for the aged are similar to foster homes except that they are larger, serve more people, and have less of the intimate family atmosphere. They are often used for former mental hospital patients and others who are not self-sufficient but cannot tolerate the intimacy of family living.

HOME CARE

Home care has numerous forms. It varies from programs offering a single service such as nursing care of the sick at home, homemaker-home health aide, or meals on wheels to multi-service patterns, the most sophisticated of which are coordinated home care programs.

Prior to the advent of Medicare, the most widespread program of home care was nursing care of the sick at home, whether provided by a voluntary nursing agency, an official health department or other source. With the passage of Medicare and its "Conditions of Participation of Home Health Agencies," emphasis is on providing services in addition to nursing, and today the multi-service home health agency predominates.

In January 1969, there were 2,184 home health agencies certified for participation in the Medicare program. Of this number, 3 out of 5 were in official health departments, 1 in 4 in visiting nurse associations, and about 1 in 13 was administered by a hospital. The range of services offered by these agencies varied. Of the total, 73 percent provide physical therapy; 48 percent, home health aid services; 20 percent, medical social services; 22 percent, speech therapy; and 16 percent, occupational therapy.

Although the intent of the law is for the attainment of comprehensive services in the home health agencies, Social Security data show that in January 1969, half of the certified agencies were at minimum certification level, and that 43 percent of these agencies had staffs of only one or two nurses. Thus while some progress has been made in expansion of home health programs, much remains to be accomplished with regard to a sharp increase in the number of agencies and diversification of services offered.

SUMMARY

Based on their ability to carry out normal roles and responsibilities, most old people function well and should be considered healthy. However, physical aging increases susceptibility to chronic illness and injury, and ability to function can be disrupted by various stresses. Major causes of death after 65 are heart disease, stroke and cancer. The main causes of disability are heart disease, arthritis and rheumatism, followed by orthopedic and visual impairments and high blood pressure.

There are many reasons why old people have difficulty in maintaining health or controlling illness: some of these are internal; some reflect attitudes and practices of health professionals; some spring from the inadequacies of the health care system; and others reflect the general social status of the aged. Despite barriers, old people utilize a great deal of health service. There is much interest currently in the impact which Medicare will have on utilization.

In general, old people need health services that are continuous, coordinated and comprehensive. Illness may be detected at an early stage by means of periodic exams, screening and sensitizing people to signs of illness. All of these methods have their limitations. Most ambulatory care of the old is given in doctors' offices, although doctors do visit the old at home more often than any other age group. Outpatient department care tends toward fragmentation and impersonality.

The expanding functions of general hospitals suggest movement toward the concept of community health

centers, in which all major health services are found in one location. Other institutions are also changing their structure and functions. Important institutions serving the aged include mental hospitals, extended, nursing and personal care facilities, and foster and boarding homes. The most neglected area of service is home care.

Information and Referral Services represent one new response to the problem of evaluating patient needs and finding help in meeting these needs. Other sources of help are available, but the problem is acute due to the disorganization of the health system and the complexity of the needs of the aged.

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THE ECONOMIC STATUS OF THE AGED

by

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About a century ago, Thomas Carlyle labeled economics as the "dismal science" and roundly condemned the political economists of his day for their preoccupation with the inequity of society. But the standard definition of economics is pretty much as follows: "Economics is the study of how men choose, with or without the use of money, to employ scarce productive resources to produce various commodities over time and distribute them for consumption, now and in the future, among various people and groups."

There are two major areas of interest to economists, namely, what resources will be used to produce what goods, and who will have claims against the goods and services produced for consumption. It is in this latter area that the economic status of the aged is of concern to economists: who gets to consume what?

MONEY'S ROLE IN THE ECONOMY

In a monetized economy, the primary means by which goods and services are distributed among consumers is through income payments. Thus, we say that one person's income is higher than that of another person, based upon the amount of goods and services he is able to buy. One important way that the amount of money income can be increased or decreased is through the price level. If prices go up and the amount of money income he receives remains the same, we are forced to conclude that his real income is reduced. However, if his money income should go up faster than the prices of those goods and services he consumes go up, we conclude that his real income has, despite the higher prices, increased.

ECONOMIC CHANGE SINCE WORLD WAR II

The advance in the level of real income in the United States in the period since the end of the second World War can be described as phenomenal. For example, the total value of all the goods and services produced in the United States in 1966 was $740 billion. An increase of 7 percent to $790 billion was foreseen in 1967. In terms of average family income, this meant $7,250 in 1966, and $7,400 in 1967. But 1967's dollars did not buy as much as in 1966, for three points of the 7 percent increase in total output would be due to price increases. Nonetheless, real family income on the average would be higher than before. Indeed, it would be the highest in American history and would represent the highest real incomes in human history.

INCOME DISTRIBUTION

But the use of average figures, when discussing income, is deceptive. An average is really only a valid measure when the distribution around it is a normal one which can be represented by a bell-shaped curve. Income is not evenly distributed. In fact, its distribution is said to be skewed, that is, instead of an equal number of people being found at both high and low incomes, many more are found below the average than above it. In fact, the families who rank in the upper 20 percent of all incomes in 1964 had 41 percent of all the income; conversely, those families and individuals who ranked in the lowest 20 percent of the income stream had only 5 percent of all the dollars.

POVERTY

The tendency of incomes to be skewed means that there are some families and individuals whose incomes

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are very low. For purposes of taking social action among these with low incomes, the President's Committee of Economic Advisors in 1964 formulated an "official" definition of poverty which has since become rather famous. It would define as poor any family of four with $3,000 or less in pre-tax income at 1962 price levels.

This initial effort to delineate the boundary of poverty was not a success. Because the needs of families differ significantly, a definition which reflected this variability was needed. To meet this need, the Social Security Administration offered a new "official" definition which took variability in individual family needs into account. Thus, this definition varied from an income of $5,000 for a nonfarm family of seven at the high side to an income of $1,000 for a farm family of two whose head is over 65.

The Social Security Administration, in formulating this new "official" definition of poverty, did then attempt to deal with the problem of the differing needs of different families, and thus take into consideration these needs in setting the basis for determining who are poor. Unfortunately, despite this work, price indexes that show the real income changes of advancing or declining prices remain to be calculated. Without them, it is not possible to say with any precision what the impact of price changes has been on particular population groups.

Poverty as an Economic Fact

While defining a term like *poverty* is difficult, it is not so difficult as living poverty. And today, in our affluent and achieving society, more than 30 million Americans are living poverty. They lived in 11.5 million households and made up 19 percent of the population in 1965. This was down considerably in both absolute and relative terms since 1959 when there were 13.4 million poverty households or 24 percent of the population.

Poverty and The Aged

In 1965, 3.8 million of the 11.5 million poverty households were headed by a person 65 or older. Like poverty among the population as a whole, the incidence of poverty among the aged has declined in absolute and relative terms in recent years. Even so, the decline has not been nearly so great for the aged as for other groups.

While the decline of poverty households in the population as a whole was 14.2 percent between 1959 and 1965, the decline in number of poverty households among the aged in the same period was only 2.5 percent. It should be recognized that this was in a period of relative price stability when compared with 1966. The persistence of poverty among aging people highlights their most outstanding economic characteristic—their lower incomes.

But as has been indicated by the data so far in absolute terms, poverty among the aged has tended to improve. The question then becomes not absolute improvement, but rather relative improvement. Are aging people sharing proportionately in the increased productivity of the American economic advance?

As Table I indicates, most people in the labor force have fared well in the period since 1949.

TABLE I

Median income of men, by age, for the United States: 1963, 1959, and 1949

Age	*1963*	*1959*	*1949*
Total . . .	$4,511	$3,966	$2,346
14 to 19 years . .	406	411	410
20 to 24 years . .	2,632	2,162	1,726
25 to 34 years . .	5,470	4,747	2,754
35 to 44 years . .	6,230	5,320	2,951
45 to 54 years . .	5,828	4,852	2,751
55 to 64 years . .	4,901	4,190	2,366
65 years and over.	1,993	1,576	1,016

The median income for women over 65 in 1963 was $920 or 46 percent of the median income for elderly men.

The relevant question, then, is how have those who have left the labor force fared in the same period? The evidence indicates that incomes of the aged have not moved so rapidly as for those still actively working on the production of goods and services. In Table I, the relative deterioration of the aged vis-a-vis the actively working population throughout the period of the fifties is shown. It also indicates that there has been some modest improvement in the period since 1959.

Table II indicates that despite this modest improvement, the relative economic position of the aged in 1963 was not as good as it was in 1949.

TABLE II

Median income of men, by age, for the United States: 1963, 1959, and 1949

[Converted to Index Numbers (35 to 44 years = 100)]

Age	*1963*	*1959*	*1949*
Total	72	75	79
14 to 19 years	7	8	14
20 to 24 years	42	49	58
25 to 34 years	88	89	93
35 to 44 years	100	100	100
45 to 54 years	94	91	93
55 to 64 years	79	79	80
65 years and over	32	30	34

Even a modest improvement is to a considerable extent deceptive, for without understanding how it has come about, we likely will mistake what the conditions of life are for most aging people.

RETIREMENT FUNDS

Primarily, the source of this modest improvement has been that those retiring most recently have been under Social Security longer and at higher wage and salary levels for a contribution base. To a lesser degree, private pension plans have been of assistance. Nonetheless, the income of males over 65 is still 70 percent lower than the median incomes of those in the most productive years, ages 35 to 44. And the relative economic position of males over 65 is not as good as it was in 1949!

On the surface, it appears that the aging should have ameliorated their lot by saving, by purchasing annuities, and by other self-improvement purchases. Yet, wage levels in the United States for those presently retired were nowhere near where they are now when the aged were in the labor force. And there have been discordant economic events which lessened the ability of workers to save even if wage and salary levels had not been so low. How does one in his saving plan make allowance for a greater depression or the kind of price inflation that hit savings in the late 1940's? Currently, such plans are participated in by fewer than 15 percent of the labor force. For the foreseeable future, Social Security will be the main source of income for most older people who have left the labor force, and for those dependent upon them.

REAL INCOME

In contrast to money income or the number of dollars individuals and families receive, real income is a measure of what the dollar received will buy. If we use the dollar's average purchasing power during 1957–59 to compare purchasing power at various points in time, we find a dollar bought only $0.93 worth of goods in 1964, or a downward change of 7½ percent. A dollar in 1949 bought $1.20 worth of goods judged by 1957–59 prices. The value of the dollar in purchasing power, then, declined by 27 percent between 1949 and 1964.

Purchasing Power Measures

As in income data, changes in the purchasing power of the dollar represent particular phenomena that would not apply to everyone equally. These figures are estimates of changes in the purchasing power of the dollar for urban families in the upper blue-collar and lower white-collar occupational groups. Since they are the basis of the Consumer Price Index, they are our single best estimate of overall changes in price levels. Over 400 items are included in the construction of the index to make these estimates of changing purchasing power of the dollar in the "market basket" of goods and services among urban wage earner and clerical worker families. The index does not precisely measure the impact of price changes of the aged.

Consumption Patterns

There are, though, some decided differences in consumer behavior that allow us to make inferences about real income changes among the aged.

The aging are higher than average users of medical services. For instance, the aged made nearly 50 percent more physician visits per year than the population as a whole and spent almost 50 percent more per year for medical services than did the population as a whole. Because of their lower incomes, a larger proportion of the incomes of the retired went for medical expenditures. Recognition of these realities was one of the major reasons for the passage of Medicare.

What is the income effect of Medicare? Obviously, if the price of goods and services which make up a large part of a family's expenditures is reduced, that family had made a gain in real income. This gain is as real as an increase in money income when prices remain the same or when changes in income received are greater than increases in prices. Because coverage under Medicare is incomplete and because prices for medical services have advanced far more rapidly than other prices, the immediate benefit of the Medicare program will be diluted with the passage of time. Not only does inflation threaten to diminish to a considerable extent the benefits to income under Medicare, but it also affects other goods and services consumed by the aged more than for the general population.

Inflation affects the aged more than the general population because of their patterns of consumption and because more of the aged derive their incomes from fixed income claims than do younger people. The interest of the aged in income adjustment to overcome inflation is complicated by their patterns of consumption. They are greater than average consumers of services which tend to rise faster in price than incomes do.

The demand for services is extremely income sensitive. As income rises, the monies expended on services rise faster. Even without inflation, the purchasing power of the dollars received by the aged would be lessened through time as the rest of the population get richer in real income terms.

The relative income of older people through time is affected several fold. First, because their incomes are fixed and based largely on contributions of previous employment, income adjustments can be obtained only through political action by the Congress. Second, the income parity of the aged tends to be diminished by the disproportionate increases in demand for services by the general population as its real income grows.

Further, the fruits of technological process are distributed through payments to the current factors of production—wages and salaries, profits and rent. The aged then can only participate in higher levels of living as they are able to derive income from one of these sources. Typically, the aged do not work. Second, a few have assets that take the form of direct profit participation. Third, while some have the potential to earn rent payments through their real property ownership, they are occupying these real properties themselves.

POLICY CONSIDERATIONS

First, some policy changes are necessary to establish a means by which both the absolute and relative incomes of the aged are protected against deterioration. But keeping money incomes automatically up with price levels of the goods consumed by the aged is only a beginning. A second step is to establish a parity level of relative incomes of the aged who have left the work force to the income levels of those who remain in the work force. What amount relative to the rest of the population should the income of the aged come to?

The policies which we presently follow leave many aging people in deprivation. It might be well to reflect upon the circumstances under which present policies were formed. In the 1930's, programs were postulated on the basis of the extensive poverty of the times. Most of these programs were, therefore, at minimum levels. I think we should ask ourselves if the intellectual technology of the 1930's is any more adequate to solve the social problems of the last third of this century than that intellectual technology would be for the solution of scientific problems.

A third policy change relates to finding a way for the aged to benefit from technological change. As the pace of technological change in the United States accelerates, the policy changes of income protection against inflation and of establishing an income parity will be sufficient. Various programs have been proposed to allow for participation of the aged, among them an income surtax based on the benefits of change to income recipients from current production which would be distributed among those no longer in the labor force.

SUMMARY

The economic position of the aged is inferior to that of the population as a whole. It is also inferior in many ways to that of the aged of the past. Changes in policy seem indicated. At a minimum, it would seem that income protection against the inroads of inflation on the incomes of the aged must be forthcoming. Further, it seems desirable that we should review the relative income of the aged in comparison with that of the rest of the population, and decide if an income level per household of less than one-third that of the rest of the population is what we think is right. Third, we should consider policy changes which would allow the aged to participate in the benefits stemming from technological change in the future.

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ORGANIZED RELIGION AND THE AGING

by
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What is religion? What is the religious life? What does religion mean to the older person? What particular needs does religion seek to meet? What is the task of the religious institution in ministering to older persons? What kinds of programs must be established, and by whom?

Religion: Definitions

Religion, in Jung's terms, is the deep center from which an individual draws the ego strength he needs to cope with the realities of life; to Tillich, religion is the human quest for meaning and for answers to the ultimate questions of human existence.[1] This quest for meaning, this achievement of ego strength finds its reality in man's relations to the deity in his personal communion and identification with One he may call God, Jehovah, or by another name as the source of power and meaning and strength in the universe and, intimately, in his own life.

Meaning of Religion to the Aging

What is the meaning of religion to the older person? Select comments by older persons themselves may be revealing:

> "Religion removes fear for me. It keeps me from fearing the future."
>
> "Thank you, Lord, for a good day!"
>
> "If you've got good equipment inside, you don't need much without!"
>
> "Sorrow drives us closer to God. I came to know Him when the first real tragedy of my life came and I was thrown completely on His care."
>
> "I hope I've grown at least a little in my understanding of God. I *think* I have."
>
> "Running away from yourself won't help. If you don't have real security, all the loud TV's and radios in the world won't help you!"
>
> About an older person by another: "What prayers that woman prays! Why, she's so sure the Lord will do what she wants, she asks Him for things she doesn't even know He has!"

The significance of these and countless other views not quoted here may be viewed in the light of recent research, religion and aging people.

RESEARCHING RELIGION AND AGING

Swenson comments on the difficulty inherent in researching the meaning of religion to the aging, calling attention to the fallibility of the hypotheses devised to date to glean this type of information.[2] Is an older person "religious" in ratio to attendance at worship services or other church activities? Is a person more religious when he attends more events; less religious when he stays away?

The study of the religious attitudes and interests of the aging is a relatively new area of interest. We know far more about the diseases of aging and even the psychological factors related to the aging process than we do about the religious aspects of older adult life.

Gray and Moberg remind us that additional research is necessary to determine the extent of religious beliefs and actions as persons age.[3] Maves adds "There is some indication that they might be more favorable than younger groups of adults in their attitudes toward religion and disposed to find religion taking on somewhat more importance. It would be more accurate to say that those who are now above 60 years of age are somewhat more religious than those who are now younger. It is not clear that this is entirely correlated with aging." [4]

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He further comments, "Religion has a relation to aging because it involves a response to the experience of aging, change, loss, and death. It involves a concern to find the ultimate meaning in these processes and to ascertain the significance of human life. It colors not only the way of looking at the process of aging and those who are aged, but the way of responding to them. Religious faith and activity may be the way a man can assure himself of his continued worth in spite of the losses and disabilities wrought by aging." [5]

Using the inventory entitled "Your Activities and Interests" in a study of 499 men and 759 women, University of Chicago social scientists found that participation in social activities decreased with age after the 60th birthday. "Nevertheless, satisfaction with religion and the derivation of a feeling of security from it increased with age. The percentage of both men and women with favorable attitudes toward religion was found to increase with age. Belief in a life after death, which was accepted by most people in their sixties, was universally accepted by all in their nineties." [6]

The Gray-Moberg study and Maves writings, as noted above, serve as the source for the points to follow:

1. Religious participation from childhood usually supports continued participation into the older years.
2. Religion is for many older persons a factor in successful adjustment.
3. Older people attend church services about in the same proportion as do persons of middle years.
4. Few older people hold places of leadership in the church.
5. Church attendance lessens as income decreases.
6. Older women participate in church activity more regularly than men do.
7. Almost all older people, like most American adults of all ages, admit to belief in God and acknowledge verbally the importance of religion.
8. The church is the one social unit that is available to the older person who is beyond retirement, has experienced changes in family structure, and has withdrawn from clubs and similar associations.
9. Religious activity is not necessarily an indication of an essentially religious concern in older adults.
10. The churches are playing a significant role in the adjustment of many older persons, but they are not, in practice, doing as much as they could do in the light of their stated purposes.

We may summarize: Religion is a more natural part of older adult life:

—When it is a part of the experience of childhood;
—When it is nurtured by a loving family;
—When it involves present satisfactions;
—When it supports a sense of personal worth;
—When it makes possible a view of the future, marked by peace and hope.

THE CHURCH

The church is the agency in society designed to help persons find value and meaning for their existence through relationship with one another *and* with the ultimate power of the universe. An individual unit of the church, a congregation, may be a simple fellowship of a few people or a large body characterized by involved organizational patterns and highly specialized clerical leadership. It may be housed in a great temple or in a "house church" where "two or three are gathered together."

Among the means whereby the church provides this sustaining relationship between man and man, and between man and God, and thus a sense of value beyond mere existence, are: the celebration of common worship; the fellowship of service and of social events; the capturing of mankind's early beginnings and searchings for truth through study; individual and corporate communion through prayer; the counsel and support of the priest, rabbi, or pastor; and the inspiration of the proclaimed word. Each move is designed to make possible a better personal and social life in the world in a context of acceptance of every person as he is.

To the older person there is particular value in such a description of the church. He needs a fellowship in which there is welcome for all persons, however limited physically or financially, as children of God who are worthful individuals. In such a fellowship, the older person is offered a place of usefulness, of recognition, of responsibility, of warm reception, and of support for waning egos.

ANCIENT TRADITION

The fact of age itself has been accepted since ancient times as an evidence of God's favor. "Honor your father and your mother, that your days may be long in the land which the Lord your God gives you."

(Exodus 20:12). "I will fulfill the number of your days." (Exodus 23:26). ". . . Keep his statutes and his commandments, . . . that it may go well with you, . . . and that you may prolong your days in the land which the Lord your God gives you." (Deut. 4:40).

The Judaic-Christian tradition thinks of long life in this way, with perhaps a hint of a question about an early death. One has often seen older persons shake their heads and ask, when a younger person died, "Why was he cut off so young?" as though there had been a deliberate act of punishment. A ripe old age has been thought blessed of God and the saints. The saints of tradition have been, themselves, persons portrayed as aged, hoary headed, possessed of long years.

HONOR RELATED TO LIFE EXPECTANCY

The fact that life expectancy was low in the days of the Old Testament, or an average of under 25 years then, under 30 in the days of Jesus' life in Galilee, may interpret the origin of the idea that old age was a special favor bestowed by God. To be old was to be exceptional—in honor, in prestige, in wisdom, as well as in age—for obviously this person, this old person, must have some special reason within himself for such a signal achievement to have been realized, such a gift of God to have been bestowed.

Down through the years this idea persisted, though the life expectancy figures have changed. Only within this century have the figures stepped up sharply enough to shake the foundations of the old idea of age as a special privilege. Those who are in the eighties, nineties, and past 100 today were studying their history books in the day when the average man lived approximately 40 years.

AGE: A MIXED BLESSING

The inescapable fact is that aging is not an unmixed blessing. Thousands of older persons are victims of long and painful diseases. Many live in want and in loneliness. Others who could still contribute to mankind are denied this opportunity solely because of societal values of aging and retirement. For these, there is bewilderment reflected in puzzled questions. "Why did the Lord leave me here so long?"

If the church is that institution most concerned with increasing the ego strength of each person and helping him feel the assurance of being truly valued in the sight of God and man, it is obligated to do all in its power to provide those experiences that will reassure and support the individual.

CHURCH PROGRAMS FOR AGING

Church programs for the aging have three dimensions: denominational-operated retirement and nursing homes; community centers, recreation programs, and sheltered workshops, usually sponsored by several congregations on an interdenominational or interfaith basis; congregational programs for their members and other older persons in the community, both active and homebound.

Retirement and Nursing Homes

Most religious groups have felt a responsibility for institutional care of the aged for many years, with creative changes being seen in this type of service today. Some "homes" comprise four or five units scattered through a city: an apartment house, a hospital, a community center, a nursing home, a residence building.

The walls of the familiar old people's home are beginning to expand as church-owned homes are becoming centers of activity in the interest of all older people of the surrounding area. More and more homes are training pastors, offering crafts and recreation, providing workshops for volunteers and professionals, giving volunteer service for community needs, furnishing foster grandparents for institutionalized children, training and deploying visitors to the homebound, and scheduling continuing education programs. The role of the chaplain in institutions for the aging is also changing. Increasingly, homes are seeking to relate individual residents to the services and fellowship of nearby churches rather than to a home-sponsored program, and to relate individual residents to the pastor and congregation rather than to an institution.

Further, denominations are beginning to work together in determining the institutional needs of the aging in the community and the best means of meeting these needs. The days of the sectarian home may be numbered. It is a rarity now to find a home's residents restricted solely to members of the sponsoring faith group, a fact due only in part to government requirements covering use of Federal funds.

Administrators and other staff of church-owned homes are increasingly being employed because of their competence in social work, understanding of the aging process, and dedication to the real concerns of older people. Protestants and Catholics have learned much from Jewish practices in requiring a high standard of excellence in home staffs. There is need for on-the-job training for existing staffs and for preemployment education on the graduate level. Universities must take

this problem seriously in setting up degree and short-term programs in psychology, education, social work, business administration, institutional management, and human development—all related to older people, as well as incorporating concepts into existing courses.

Community Social and Workshop Programs

Community centers, housed in church buildings or other structures more convenient to the people, may be sponsored by religious organizations. In general, these are interdenominational or interfaith in management and provide social contact, useful activity, creative new experiences, and broadening of relationships for older persons of the entire community.

Such centers are often forerunners of programs provided by the community through public or broad-based nonprofit sponsors. Concerned churchmen make their services available in either situation, as an expression of commitment to the betterment of older persons' lives.

Most older adults are in the community, not in the institution. Scarcely 5 percent are residents in all the nursing homes, hospitals and homes for aging—municipal, Masonic, private, church or of whatever sponsorship. The rest are in the private houses, apartments, small hotels, one-room arrangements over stores, housing developments, or boarding homes found in every town and city. Some are learning what it is like to be citizens in a homogenized, self-contained village of older persons.

The need for an outlet for personal abilities and for a source of income for physically and emotionally limited persons has found a worthy solution in the sheltered workshops being developed in some cities. Religious organizations manage other workshops under various titles. In all of these, persons of retirement years are given opportunity to rebuild their self-respect as contributing members of society as they produce serviceable objects for sale. Few workshops have been developed to serve only the aging person.

Ministry to the Aging

The congregation's ministry to the aging may be described from three viewpoints: characteristics, purposes, program or activities. Some basic highlights are listed below, albeit in brief form.

The first listing pertains to select characteristics of the congregation's ministry. They are:

1. Planned and led by older persons;
2. As varied in content and procedure as the number of individuals involved;
3. Geared to use the creative skills of younger persons;
4. Keyed to the concerns of persons at many levels of experience throughout the entire span of the older years;
5. Inclusive of all older adults, not just those of the congregation's membership;
6. Related to community resources; and,
7. Involved with the services of a concerned designated worker responsible to the church staff.

The purpose of ministry is to help meet the spiritual, emotional and health needs of the aging person. Related to this are the important issues of:

1. Changing and improving societal attitudes toward the aging process and older persons;
2. Providing support to younger persons in their quest for a meaningful life in the present, to prepare for a happy life in the later years; and,
3. Contributing to the community's recognition of the needs of older persons and the development of community resources to meet these needs.

Program features that have been included in the congregation's plans for older persons have varied dimensions. Such program activity entails fun times such as singing, parties, camping, and sports. Other activity is built about intellectual stimulation through activities such as book reviews, bible study, and group discussions.

A third activity arena is one of utilitarianism and service to others. Activities suggested may be to visit the homebound, to assist in voting drives, to carry out congregational responsibilities, or to work for desired legislation, again among multiple possibilities.

What has been said here for the congregation's ministry is applicable to the program of the community center as well as the retirement and nursing home where needs expressed and unexpressed are the stimuli for group planning.

SOCIAL WORKER ROLES

Social workers are invaluable at many points in planning. In training, their help would be particularly useful in developing skills in group decision-making, in use of consultative principle and methods, in awareness of the deep problems of individuals, and in assessing progress and determining next steps. As seminaries and

colleges develop broader training for clergymen, social workers' insights will be invaluable in courses on pastoral care and counseling.

There are other means whereby a professional social worker may help religious organizations serve the needs of the aging besides letting the church know one is available. Social workers are skilled in training visitors to the homebound aged, in providing resources on health maintenance, finances, housing, rehabilitation, community services, in initiating workshops or conferences, in helping plan community centers and other community services which churches can house and sponsor, and in assisting church-sponsored homes for aged in developing community service patterns.

CONCLUSION

Religion and the church are intimately involved on a spiritual, emotional and psychological base to serve a specific church membership. In so serving its congregation, the church is moving to serve all aging people who so desire it.

While significant research in religion and aging has been undertaken, more remains to be learned than what is now known. Religion is a positive factor in the later years. And to maximize its place in serving mankind, the church has moved to meet the needs of aging people on an individual, group, communal and societal basis.

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ATTITUDES OF THE ELDERLY TOWARD RELIGION AND DEATH

by

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". . . Man is the wonder of the world because he is the master of the ageless earth, bending that mother of the gods to his will; because he is master also of living things: because he overcomes all changes, all the dangers, finds the remedy for every ill . . . every ill but one: Death he cannot overcome. Why, then, is he the wonder of the world? *Because* he dies: because, in spite of death, in spite of his foreknowledge of death, he masters nevertheless the ageless earth, tames beasts, builds cities." [1]

TWO DRIVES OF MAN

Despite the fact of death, its inevitability and universality, man exhibits two basic drives or impulses: the impulse to live, to maintain himself in being, to preserve himself; and the impulse to improve, to live better, to enhance the quality of his living. He seeks security, order, the regular and dependable results, the balance necessary to his preservation. He also seeks the new, aspires to the as yet unachieved. He reaches for, even longs for, "increased perfection" as Spinoza suggests, or for "excellence" of life as Aristotle among the ancients and John Gardner currently suggest. He even risks his life and shows the courage to accept the risk to progress.

Of course, not all men illustrate these two drives to an equal degree. Those with suicidal tendencies may be exceptions, though suicide may be pathological. As Fromm suggests, ". . . experts on suicide believe that most acts aimed at self-destruction, whether or not they succeed, are really attempts to reach out for others—ill and awful ways of crying, 'Help me!' " [2]

Bereavement, poor retirement adjustment and lack of appropriate alternatives or other hazards of aging can engender the "will to die." Then there are the dull and unimaginative, those hindered by ill health, those stunned by neurotic anxiety, those enslaved by the rigors of tradition and unexamined custom and dogma, who do not aspire to better things.

Nonetheless, man functions as a balance-aspiration creature. Stability and progress appear in all human life and experience, and they appear as a working couple: balance allows us to survey where we are; aspiration urges us to journey forth. Human life goes on in the face of the population problem, man's inhumanity to man, the fact of death.

MAN'S CONTEMPLATION OF DEATH

Hocking, who believes that the meaning of life and the meaning of death are inseparable, states: "Man is the only animal that contemplates death, and also the only animal that shows any doubt of its finality." [3] Feifel states: "As far as we can determine, man is the only animal who knows consciously that he has to die." [4]

Man's Range of Thought About Death

Man's contemplation of death is profoundly varied. Marcuse, in indicating the general range of thought about death, observes: "In the history of Western thought, the interpretation of death has run the whole gamut from the notion of a mere natural fact, pertaining to man as organic matter, to the idea of death as

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the *telos* of life, the distinguishing feature of human existence. From these two opposite poles, two contrasting ethics may be derived: on the one hand, the attitude toward death is the stoic or skeptic acceptance of the inevitable, or even the repression of the thought of death by life; on the other hand, the idealistic glorification of death is that which gives 'meaning' to life, or is the precondition for the 'true' life of man." [5]

Saunders has noted that "Death is feared, all thoughts of it are avoided, and the dying themselves are often left in loneliness. Both in their homes and in hospitals, they are emotionally isolated even when surrounded by their families or involved in much therapeutic activity. When we do come near them we tend to look at them with that pity which is not so far removed from contempt. Concentrating on our own reactions to death we often fail to learn the respect for the dying that can help us find the real meaning we both need." [6]

View of Death by Old People

The psychological and/or emotional states in which old people approach death, whether viewed as "natural fact" or as "the distinguishing feature of human existence," range from joyful expectation to extreme and pathetic terror. No single, uniform attitude is traceable among the aging and aged toward death. Attitudes toward death may be reflected in such diverse categories as "welcomers, accepters, postponers, disdainers and fearers." [7]

For the aging individual, however, the attitude towards death is significantly different from other individuals. Especially noticeable is the fact that death is not a matter of academic discussion for the aging person in the declining years of life. He is considering the unavoidable circumstance of his own death; he is involved in the realization that his life is drawing to a close. Many dying patients may look to professional personnel, as well as families, for comfort and assurance in the face of death. Ross gives a striking illustration of this point: "Most dying patients wish to talk about death. They welcome a breakthrough of their defenses. They welcome a frank, unemotional, honest discussion of their feelings." In these situations, Ross feels, it is imperative that the practitioner be aware of his own feelings about death in order to sustain a relationship with the dying person and his family.

"We have lost the ability to talk about death calmly," she states, "to sit and listen to a dying man to hear what he is so eager to share with us." She suggests that this "peculiar immunity" to death may be the result of a "projection of our anxiety, our inability to face the true facts," our reluctance to "help patients die." [8]

Personality Involvement

De Ropp believes that "people differ tremendously in their capacity to face death," depending upon their religious and cultural background as well as their philosophy and life experiences. He writes of three types of aging persons facing death:

1. The "cerebrotonics" who face death freely, perhaps even in joyous anticipation, and who sometimes die with a pleasant smile.
2. The "somatonic" who is aggressive or boisterous as he approaches death, who tends to be careless and fearless of death, or who does not fear death more than anything else.
3. The "full-bellied 'viscerontonics' " who, quoting William Sheldon, de Ropp says have a "devil of a time of it, dying with great protest as if they were being torn from life ultimately by the roots." [9]

Often, the basic personality pattern of the individual is reflected in his solution to the life-death problem. A California study of aging, with reference to personality traits and attitude toward death, showed that reactions of calm acceptance and counterphobic activity to ward off death were equally significant, with anxious recognition running a close third. Unrealistic estimate of life expectancy and wish for death were the lowest in the grouping, disregarding a small variety of other responses.[10]

This same study, which was based on a group of 87 men between the ages of 55 and 84, disclosed the following five attitudes toward aging: positive attitude, armored defense, "easygoing rocking-chair" type, anger, and the self-hater.

Those in the first three groups were classified as well-adjusted, as compared to the fourth and fifth who were referred to as poorly adjusted. It is also significant that 28 percent of the men studied gave no information concerning their attitude towards aging and death. The supposition is that for many of these the "anxiety was so great that it precluded open discussion." [10]

Swenson, in his study of the attitudes of the elderly towards death, tried a cross-section of old people. Thirty-four people over 50 years of age set up the material to be used on a group of 200 over 60 years of age.

The attitudes toward death of the group of 34 persons (over 50 years) who wrote essays fell into three major classifications:

1. *Positive or optimistic,* as illustrated by these statements: "It will be wonderful," "Promise of a new and better life," "All troubles will be over";
2. *Evasive or apprehensive,* as suggested by these comments: "Don't think about it," "Have nothing to do with the subject," "Feel fine and no reason to think about it"; and,
3. *Fearful,* "The end of everything," "Terror overcomes me," "Dread the thought of it."

Analyses of the responses of the 200 persons who were 60 years or older illustrated 3 rather well-defined attitudes: Those looking forward to death positively—45 percent; those avoiding any thought of death—44 percent; and those fearing the death experience—10 percent.[11]

A study done by Jeffers, Nichols and Eisdorfer involved 269 community volunteers 60 years of age or older.[11] During a 2-hour social history interview, as part of a 2-day examination, one question asked the subjects, was: "Are you afraid to die?" Ten percent responded "yes," and 35 percent "no." Fifty-five percent responded "no" with the following qualifications:

1. No, but it is inevitable—17 percent
2. Mixed feelings (balanced ambivalence)—16 percent
3. No, but want to live as long as possible—13 percent
4. No, but do not wish to be sick a long time—4 percent
5. No, with other elaboration—3 percent
6. No, but dread the pain of dying—2 percent

RELIGION AND AGING

In the Jeffers study, it was further observed that the unqualified "no" answers were associated with religious terminology; the answers suggesting *ambivalence* were associated with an absence of religious connotations; and the answers *admitting fear of death* tended to have no religious connotation.

"It therefore appears that the factors associated with *no* fear of death include a tendency to read the Bible oftener, more belief in a future life, reference to death with more religious connotations, fewer feelings of rejection and depression. . . ." [11]

This conclusion is virtually the same as the one drawn by Swenson: "Persons engaged in frequent religious activity . . . evidenced a very positive or forward-looking death attitude, whereas those with little religious activity or interest either evaded reference to death or feared it . . . Religion and religious activity apparently play a very intrinsic role in the gerontic individual's concept of death . . . . The obvious conclusion here is that the person of firm Christian beliefs or convictions has a more positive religious orientation and, therefore, looks forward to the experience of death." [11]

Religious and Nonreligious Old People

In comparing the religious with the nonreligious, Feifel affirms evidence of almost the opposite conclusion from that of Swenson and Jeffers. "The religious person," he writes, "when compared to the nonreligious individual, is personally more afraid of death. The nonreligious individual fears death because 'my family may not be provided for,' 'I want to accomplish certain things yet,' 'I enjoy life and want to continue on.' The emphasis is on fear of discontinuance of life on earth—what's being left behind—rather than on what will happen after death. The stress for the religious person is twofold: concern with afterlife matters, 'I may go to hell,' 'I have sins to expiate yet'—as well as with cessation of present earthly experiences. Data indicate that even the belief that one is going to heaven is not sufficient to do away with the personal fear of death in some religious persons. This finding, together with the strong fear of death expressed in the later years by a substantial number of religiously inclined individuals, may well reflect a defensive use, so to speak, of religion by some of our subjects. In a corresponding vein, the religious person in our studies holds a significantly more negative orientation toward the later years of life than does his nonreligious peer."

The contrast between Swenson's findings—that the more fundamentalist one's religion and the greater his religious activity, the more positive his attitudes toward old age and death—and the findings of Feifel—that the religious person holds a significantly more negative orientation toward old age and death than does the nonreligious person—is striking. At this juncture, the question of the nature and function of religion is crucial. Neither Swenson nor Feifel makes clear how he uses the term.

RELIGION: AN INSTITUTION AND A WAY OF LIFE

A distinction, though not an ultimate separation, can be drawn between the religious institution and religion as a "way of life." Historically and currently, the religious institution has a number of functions in society. It conserves and safeguards the values of a people; it is a place of refuge, worship, self-examination, recreation; it gives instruction in values and the most equitable conditions and ways of human relations; it is a source of personal and corporate strength in the most intimate sort of community relation—a full reciprocity of persons.

As a way of life, religion aims at unification, at being all-inclusive, coextensive with the whole of life. It means to intensify, sanctify, enhance every human function, faculty and activity; to make men reinterpret and revalue the so-called secular aspects of life and to give such fuller meaning; to foster and nurture a sense of personal integrity and dignity in relation to the larger world about, including death. Clearly not every individual in every religious faith, denomination, sect and congregation will settle for this statement about the religious institution and the religious way of life; nonetheless, some such statement is clearly within the mainstream of the Jewish and Christian tradition.

Linstrom makes much the same point when he writes, "It is generally recognized there are two basic functions of religion and these have different bearings on an analysis of religion and the aging. The primary function of religion is that of interpreting a meaning of existence and promoting ultimate values for individuals. A secondary function is that of providing a social activity and opportunity for interaction with others—not necessary (sic) opposition to the primary function, but as a part of a total approach to life. Churches are increasingly recognizing and dealing with 'the total man;' that is, with a recognition of a relationship between the spiritual aspect of man and his existence and relationship to God and the relationship of man within himself and as a social being. While both are recognized generally as legitimate functions of religion, today there is a variation in the extent to which churches see each as their responsibility. There is also a wide variation in the extent to which individuals respond to organized religion on the basis of one or the other function." [12]

While noting that ". . . studies which have been carried out tend to support the fact that there is a positive relationship between a good adjustment in later years and church participation or activity," Linstrom further observes that "churches have both positive and negative effects on the adjustment of older persons" Thus, he argues, ". . . there is a need for more extensive acceptance of responsibility on the part of organized religion for its potential role, in assisting with the adjustment of older persons in society." [12]

To Linstrom's views I would incorporate the need for continued instruction, to bring into view or *re*-view the central, positive teachings from the religious perspective on life and death. Churches sometimes restrict their teaching function to children and young people. "Continuing education" is with us!

Koestenbaum's "Summary of the Salutary Consequences of Death" is intriguing and his points are listed herewith for assessment:

> "1. Man cannot escape death—*real* or symbolic . . .
>
> "2 Once he has recognized and admitted the inevitability of his death, the individual is on the way to becoming courageous, fearless and decisive . . .
>
> "3. By remembering the certainty and finality of death, man immediately sees the urgency of concentrating on essentials . . .
>
> "4. Only through the constant awareness of death will an individual achieve integrity and consistency with his principles . . .
>
> "5. The man who knows he will die wastes no time in attacking the problems of finding meaning and fulfillment in life . . .
>
> "6. The vitality of death lies in that it makes almost impossible the repression of unpleasant but important realities . . .
>
> "7. The realization of the death of myself leads to strength . . .
>
> "8. To accept death means to take charge of one's life . . .
>
> "9. The thought of death urges one to assume a total plan of life . . .
>
> "10. The thought of death enables men to laugh off vicissitudes and pains." [13]

Perhaps. And should these "salutary consequences" be considered within the teachers of the church?

CONCLUSION

Religion is deeply involved in the meaning of death to aging people although research has not come to a consensus in findings, even though it has been shown that the personality pattern of the individual reflects his death attitude. And while studies indicate a positive relationship between a good adjustment in later years and church participation, there is apparent need for continued religious instruction to bring into view or *re*-view the central, positive teachings from the religious perspective on life and death.

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WORKING WITH OLDER PEOPLE—SUMMARY PAPER

by
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Older people may be rich or poor, gregarious or isolated, well or ill, irritable or serene. Regardless of economic level or social values, regardless of the condition of health, both physical and emotional, older people face particular problems and experience certain difficulties in finding solutions.

This volume represents a catalogue of essential knowledge presently available relating to the daily lives and needs of older people. It identifies and specifies problems in the areas of physical, emotional and social needs and delineates a variety of solutions our society has developed through community services.

DETERMINING AND MEETING PHYSICAL NEEDS

The broad categories of food and nutrition, shelter, clothing and safety of physical environment are needs shared alike by all age groups, but with certain differences noted for the elderly.

Food and Nutrition Counseling

Food is a primary need for life. Its consumption can be a source of great pleasure to older people and is both a nutritional and often a social experience. Factors related to food consumption suggest:

1. Need for fewer calories
2. Gradual reduction is basal metabolic rate
3. Poor appetite and faulty absorption, resulting in vitamin deficient diets
4. Decreased perceptions in taste and smell

To maintain good nutrition, older persons experience certain difficulties such as: inadequate protein nutrition and excess carbohydrates in diet due to low income, loss of teeth or poor teeth, and disabilities that pose problems in using eating utensils; certain common illnesses which require special adaptation; and difficulty in shopping for food and in obtaining food in small packages.

The emotional and social dynamics of food and eating are particularly significant for older people. For those who live alone, there is little motivation to prepare adequate food. Loss of appetite may result from anxiety and internal tensions. On the other hand, eating in a compulsive way may represent compensatory behavior for emotional isolation, loneliness and other stress.

Cultural, religious and regional dietary habits are comforting and are not easily modified. The social aspects of eating are often appetite stimulators, for habits of entertaining guests with food or eating with others are powerful motivating forces for older people.

Some available solutions have made it possible to meet several of these needs through new frozen foods and their packaging, restaurants, boarding houses, and portable meals served in the home (Meals-on-Wheels). Even in congregate care facilities, a selective menu system helps offset depersonalization.

Social work and other counseling in regard to the food and nutritional needs of older people include establishing the extent and duration of the person's needs. This would involve contacts with the older person's family, his physician and others in developing an assessment of the older person's capacity to take care of all or part of his food needs, either temporarily or over an extended period of time.

Based on this assessment, counseling can then assist in working out suitable plans to meet the specified needs within the available resources in the particular community, if the older person is to have his nutritional needs met while continuing to live at home.

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The assessment may, of course, reveal that the older individual has other needs in addition to those related to food, suggesting a broader base for planning and counseling.

Shelter Counseling

Independent living either in homes or apartments is the shelter preference of older people. They prefer not to live with their adult children or with their siblings. Among the factors affecting this preference are:

1. Decreased ability to adapt to temperature change
2. Vision and hearing deficits
3. Tendency to frequency of falls
4. Increased susceptibility to infections
5. Too large homes with increased potential for accidents
6. Income capacity to enter rental market greatly reduced
7. Reluctance to move from familiar surroundings
8. Disabilities which prevent effective search for other shelter

Security, status and independence are implicit values in home ownership. Thus, a move from the familiar home and neighborhood represents a severe trauma to which accommodation is difficult. Moves from independent living to the home of relatives, either children or siblings, may be a successful answer or may bring severe stress to all concerned, depending in large part on the pattern of relationships previously existent.

Societal solutions for special shelter needs of the elderly include assistance in remaining in independent living, in developing congregate care facilities, and stimulating foster home or boarding programs.

Decisions regarding shelter needs of elderly persons must recognize the depth of emotional involvement in the moves of older people.

Families are fearful of the risks of an older person living alone. The older person himself, though, often prefers independence to alternate family plans deemed safer for him.

Counseling as to judicious combinations of services may result in a successful home plan. Such combinations might include the use of visiting nurses, portable meals served in the home, homemaker and/or other services, as appropriate.

Where higher levels of care or more continuous health care is required, effective counseling may direct the person's family to appropriate congregate care facilities, assisting the family members to understand their own feelings of guilt and to accept the realities of need requirements.

Clothing and Counseling

Clothing is a more personal form of shelter in terms of providing warmth and protection. Clothing also represents an expression of a person's sense of self, his self-image and a process of self-adornment related to normal ego processes. Relevant factors in clothing for older people include:

1. Enlarged waistlines
2. Ease in the putting on and the taking off
3. Flexible and lightweight garments for comfort
4. Washable, stain-resistant materials

Older people experience special problems in procuring appropriate and attractive clothing, due to multiple factors such as lack of material and color selection in larger sizes, lack of suitable small styles, difficulty in finding comfortable, modest cost shoes, and difficulty in shopping.

Social workers, occupational therapists and others counseling in terms of clothing needs can direct people to shops specializing in appropriate clothing, including clothing adapted to those with special disabilities.

Environmental Safety

A high proportion of older people are involved in fatal or disabling home, road and pedestrian accidents. Relevant factors relating to accidents involving the aged include:

1. Decreased visual acuity
2. Failing hearing
3. Loss of sense of smell
4. Decrease in muscular skills, endurance and coordination ability
5. Slower reaction time
6. Poor memory and attention

Major causes of home accidents relate to stairway and object falls, while institutional accidents deal with fires and wheelchair-bed-bathroom falls.

Driver accidents are related to diminished vision and reflexes while improper intersection crossing, walking on roadway and jay walking cause pedestrian accidents.

Families of older people, or older people themselves, are often unaware of the many simple adaptations that can be made in a dwelling to make it safer for an older person to live in. These include telephone access, dis-

tinct medicine labeling, grab bars, nonskid steps, better lighting, and easily reached cabinets, among others.

Institutional staff training in safety procedures and stringent inspections and standards of licensing authorities, working together, can reduce accidents and injuries.

Solutions for drivers have been approached by senior driver education courses, driver reexamination requirements for aging drivers, and older-driver seminars. Pedestrian education programs and pedestrian escort services are two approaches toward solving the hazards for older pedestrians.

EMOTIONAL NEEDS

Warm satisfying relationships, a sense of worth and accomplishment, choices and alternatives in terms of self-mastery, mobility and independence, strong spiritual convictions to sustain and support the stresses of final illness and death—all these are primary emotional needs of older people.

Since older people must accommodate to many severe stresses, supportive and sustaining relationships are vital. Stimulating programs and services are essential to meeting these special emotional needs of the aged.

Satisfying Use of Leisure Time

For the majority of older people who are still active and able, retirement time on their hands poses challenges to find new roles to play outside the normal work role, new opportunities for community service, new chances for personal gratifications. Successful solutions in the use of time are key factors in the morale and self-image of the aging person.

Community programs of great variety and in many settings can assist older people in developing creative uses of their leisure time. Examples include senior citizens centers, golden age clubs, adult education courses, self-organizations of retired persons, and programs in institutional care settings.

Assisting older people to develop effective new roles—in community service, in helping others, in the arts, in all areas which bring deep personal satisfaction and a feeling of accomplishment to older people—is the direction of social programs. As such, one needs to consider the cultural values of work, family relationship satisfactions, freedom to choose what one wishes to do or not do, and individual variations due to health-social-education-cultural background.

Mobility

The ability to move about independently, at home and in the community, is an essential ingredient in supporting the older person's feelings of self-mastery and his pursuit of creative new interests and retaining ongoing and new relationships with family and friends. Relevant factors relating to continuing mobility and independence of the elderly include walking and exercise, good foot care, especially designed furniture and buildings, individually matched assistance equipment, and convenient, low-cost and safe public transportation.

Programs to assist mobility have included public building ramps, color as guide, wheelchair wide elevators and doors, reduced non-rush-hour fares on public buses, and lower steps for bus boarding.

Social workers, physical therapists and others counseling as to improved mobility for older persons can not only provide detail on mobility aides for individuals but also are responsible for implementation of communal aides.

Organized Religion

Participation by older people in organized religion can be an emotionally supportive experience, in terms of relief of anxiety about death, comfort at times of bereavement and the promotion of ultimate spiritual values. We have learned there is a positive correlation between religious participation and adjustment to aging, and that continuing participation by older people in organized religion relates to previous religious participative family life patterns.

While organized religion offers certain direct services to the elderly, such as varied types of housing, health programs, and counseling and chaplaincy services, disabilities affect the older person's attendance. Active church roles for the aging often become restricted to honorary roles.

Recognizing that spiritual beliefs and strong church ties are emotionally supportive to many older persons, social workers and others counseling in the general area of emotional needs often work closely with individual priests and ministers or groups of clergy in efforts to mobilize the resources of organized religion on behalf of older church members.

Death

Both the dying patient and members of his family have the need for considerable emotional support during the final stages of a terminal illness.

Because death of an older person often occurs in an institution, staff training should include the following guidelines:

1. Maintenance of dignity of the aging person in death, as in life;
2. Importance of the comfort of companionship to dying patients;
3. The permitting of the patient to express his feelings about death; and
4. Supporting the staff practitioners who are handling dying patients.

Families of patients need understanding and patience during terminal illness of patient. Such understanding should include knowledge about the religious and cultural patterns relating to the patient's and family's ability to meet the crisis of death.

SOCIAL AND OTHER SPECIAL NEEDS

Security and health care as well as economic, legal and protective needs are all particular areas of special concern. Also important is the need for social work counseling and overall planning, including information and referral services, so that appropriate and direct service solutions of all kinds may be available to older persons at their specific points of need.

Security and Health Care

A major concern of older people is their health and the high costs of illness. The 1965 Social Security Amendments created a partial answer to this problem in establishing a broad program of health insurance, the Medicare and Medicaid Programs. Relevant factors to health care needs show that:

1. Most aging persons are ambulatory and receive health care on an outpatient basis.
2. Four out of 5 of those over 65 years have at least one chronic condition or impairment.
3. Aging persons tend to delay seeking medical care until a medical crisis exists.
4. Lower income and social groups do not utilize health facilities available to them.

Society has created a wide range of services to provide comprehensive health care for the elderly. Since its development and utilization vary greatly in the United States, counseling to assist the older person to obtain the appropriate health service is of great import.

Security and Income Maintenance

Adequate income for living with a degree of comfort and dignity is a primary security need of older people. It is known that in 1967, half of the aged families had incomes under $3,928, and half of the elderly living alone or with non-relatives had incomes under $1,480.

With employment as a source of income for those over 65 a diminishing opportunity, Old Age Survivors and Disability Insurance and public and private retirement programs are increasingly important.

Older people are sometimes unaware of certain economic resources available to them. Social work counseling is of great assistance in providing information to older people on all these resources, and can frequently make it easier for them to obtain appropriate benefits.

Legal Protective Services

The special needs of elderly people unable to manage their own affairs without help and who may be unable for one reason or another to request such help may require legal protection. Careful assessment of one's incapacity relates to judgment in management of money, self and home. Too, loss of competency is not always irreversible, implying the need for periodic reevaluation.

Counseling and Casework

Counseling and casework services undertaken through public and private auspices are often needed by older persons and by members of their families. Such services are needed not only at point of crisis, but on a preventive or maintenance basis. Because of extreme stresses of the aging period, supportive casework can help older persons adapt more successfully to changes in their life situation.

Counseling areas may relate to personal and emotional adjustment, family relationship conflicts, recreation, housing, employment and the full range of subjects covered herewith.

Information and Referral Services

One of the new kinds of agencies providing counseling to older people is the Information and Referral Service available in a limited number of communities.

This service can serve as a central point for information about community resources available to older persons and their families and can also arrange for direct referral to these resources. Its value is directly related to the professional competence of techniques, assessment and service alternatives.[1] [2] A most vital key is the professional judgment of the caseworker who guides the decision making.

GENERAL CONCLUSIONS

Working with older people requires a wide range of knowledge on the part of practitioners in the field of aging. The variety of solutions available at present through the development of community services also demands the most creative efforts possible of all practitioners, most particularly professional social workers in this field, to be alert to locating and implementing the right service to the older person at the right time in response to his specific needs.

In this regard, much needs to be done on all levels—national, State and community—to develop a complete network of services to older people. Social workers and other health personnel, through such coordinated programs as information and referral services, multipurpose agencies for older people and counseling services, in whatever setting they are located, can make a major contribution to the continuing dignity and individuality of the lives of older people.

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